Lectures ON THE PHYSIOLOGICAL PATHOLOGY OF THE BRAIN.

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LECTURE III.—PART VII.[1]

ON PARALYSIS OF LIMBS AS AN EFFECT OF DISEASE OF THE MEDULLA OBLONGATA AND NEIGHBOURING PARTS.

Direct paralysis is more frequently caused than cross paralysis by lesions of the medulla oblongata—Lesions of posterior parts of the medulla oblongata can produce direct or cross paralysis—Lesions of the anterior pyramid cause more frequently direct than cross paralysis—Lesions beginning inside of the pons Varolii differ radically from lesions beginning on the surface of that nervous centre—Lesions beginning inside of the pons, if they cause paralysis, produce it almost always in the ordinary crosswise manner—Pressure upon the pons Varolii either from behind, from the side, or from the front, produces more frequently direct than cross paralysis, even when the pretended motor tract is considerably altered either in the pons or in the crus cerebri or medulla oblongata.

To those who admit the view that the right side of the brain is the seat of the will-power for the movements of the left limbs, and that the left side of that great nervous centre is the mover of the right extremities; to those who admit that paralysis of limbs caused by an organic disease in the encephalon is the result of the loss of function of the diseased part, it must be absolutely impossible to explain the cases I have just mentioned (see THE LANCET of Sept. 27th), as in all but a few of those facts the paralysis should have been on the side opposite to that of the lesion, or on the two sides, instead of being merely on the very side of the disease. The existence of such facts furnishes, as I have already stated, a powerful argument against the admitted views concerning the mode of origin of paralysis and the physiology of the brain as regards voluntary movements. But this argument acquires a much greater power from the following result of my researches on the relative frequency of cross and direct paralysis in cases of certain lesions of the isthmus of the encephalon. I find that lesions of any kind located almost in any part of either side of the medulla oblongata, and also lesions of one lateral half of the pons Varolii due to pressure from outside, especially from a tumour on its antero-lateral surface, produce more frequently a direct than a cross paralysis. On the contrary, lesions of a lateral half of the pons Varolii beginning inside of that half very rarely indeed produce a direct paralysis. I have hardly been able to collect more than seven cases of such a lesion producing paralysis of the limbs on the corresponding side.[2] Cross paralysis due to an internal disease of one side of the pons is observed so frequently that, in researches I have made on the diagnosis of such a lesion, I have collected more than two hundred such cases. There is no doubt whatever, then, that according to the part first affected in cases of lesion of the pons there is a greater frequency of cross or of direct paralysis. Not so for the medulla oblongata, as shown by a comparison of the facts I will now give with the facts I have previously mentioned.[3] In this nervous centre there is no difference between those parts, which according to generally received notions should not give rise to paralysis, and those parts which ought always, according to most physicians and to a few anatomists (especially Huguenin and Flechsig) and physiologists (especially Dr. D. Ferrier), give rise to cross paralysis. Either one or the other of these different parts, when they cause paralysis, will produce it much more often on the side of the lesion than on the opposite side. The only cases I know of disease strictly limited to the medulla oblongata and located in one of its lateral halves, which had caused a cross paralysis of one or two limbs, are the following:—1. Paralysis of the *right* limbs; a patch of softening and a very small clot of blood at the place of the common nucleus of the facial and abductor nerves, near the eminentia teres on the *left* side.[4] 2. Paralysis of the *right* limbs; a small glioma on the *left* side of the fourth ventricle, involving the common nucleus of the facial and abductor nerves, near the eminentia teres.[5] 3. Slight paresis of the *right* arm; a tubercle in the *left* half of the medulla oblongata.[6] 4. Paralysis of the *right* arm; *left* half of medulla oblongata, at level of anterior pyramid, compressed by displaced and hypertrophied odontoid process.[7] 5. Complete paralysis of the *right* arm, incomplete of the *right* leg; in the thickness of the *left* anterior pyramid, in the upper part of the medulla oblongata, there was a tumour of the size of a small Spanish chestnut.[8] 6. Paralysis of the *left* limbs; aneurism of the *right* vertebral artery pressing on the anterior pyramid and the olivary body.[9]

These six cases are the only ones I know of cross paralysis due to a lesion limited to a part or the whole of a lateral half of the medulla oblongata. In the first two (Hallopeau's and Dr. Broadbent's) there was a lesion in the posterior part of the left lateral half of that nervous centre at the place of the common nucleus of the facial and abductor nerves. In several of the cases I have related of direct paralysis (Couty's, Dr. Waters' of Liverpool, and Lebreton's), the seat of the lesion which was more extensive must have included that same part. In one of the six cases of cross paralysis I have just mentioned (Bayle's) the seat of the lesion is not well defined, but in the three others (Bouchard's, Brousais', and Fontorbe's) there was a lesion of one of the anterior pyramids and of the neighbouring tissue. This is what was found in more than seven of the cases of direct paralysis I have related.

If we now add to the cases of disease entirely limited to the medulla oblongata those, like the three following, in which, with a disease in that organ, some lesion coexisted in other parts, we find that the number of such cases with cross paralysis is also smaller than the number of cases of direct paralysis. In a case of Yelloly's[10] there was paralysis of the *right* limbs caused by a tumour sunk into the pons at its posterior part, on the *left* side, extending to the corpus pyramidale of the same side. In a remarkably well recorded case of Dr. Samuel Annan[11] there was complete paralysis of the *left* limbs, due to a considerable lesion of nearly the whole *right* half of the medulla oblongata and the lower and anterior part of the *right* side of the pons, from pressure by a tumour two inches long. In a case due to an excellent observer, Dr. Thomas Buzzard,[12] paralysis of the *left* limbs had existed, and two lesions were found—one in the *right* half of the medulla oblongata, which was twice the width of the left half, owing to a tumour chiefly prominent at the place of apparent origin of the hypoglossus nerve; and the other in the *left* half of the cerebellum. These three cases (admitting that in the last the cerebellar lesion had no share in the paralysis) are very similar as regards the lesion of the medulla oblongata to five or six of the cases of direct paralysis which I have mentioned (Parent-Duchâtelet and Martinet's, Gama's, Jobert de Lamballe's, Calvin Ellis's, Dr. J. W. Ogle's, and Penard's).

It seems evident, then, that lesions occupying the same part of the medulla oblongata, whether that part be considered as motor or not, can produce either a cross or a direct paralysis, but will more frequently cause this last

[1] Part VI. of this lecture appeared in THE LANCET, Sept. 27th, 1879.

[2] To the cases I have quoted of E. Stanley, J. Toynbee, Dr. G. May, Dr. J. Browne, Martineau, and Darolles (see THE LANCET, Sept. 27th, p. 452), I might have added a few less positive, among which is one of Mr. G. W. Callender (St. Bartholomew's Hospital Reports, vol. v. 1869, pp. 8, 9). In this last case the patient, trying to walk, staggered, and his *left* leg gave way. The *left* posterior half in the entire thickness of the pons was diffluent and considerably disorganised.

[3] See THE LANCET, Jan. 4th, 1879, pp. 1 and 2, and Sept. 27th, 1879, p. 451.

[4] Hallopeau: Bulletins de la Société Anatomique (Paris, 1876), p. 450.

[5] Dr. W. H. Broadbent: Transactions of the Clinical Society (London, 1872), vol. v., p. 66.

[6] Bayle: Traité de la Phthisie Pulmonaire (Paris, 1810), p. 155, obs. 8.

[7] Bouchard in Hallopeau's thesis: Des Paralysies Bulbaires (Paris, 1875), p. 118.

[8] Brousais: Traité des Phlegmasies Chroniques (3ème édit., Paris, 1822), p. 429.

[9] Fontorbe: Un cas d'Hémiplégie Alterne par Anévrysme de la Vertébrale. Thèse Inaugurale (Paris, 1874), No. 313, p. 5 *et seq.*

[10] Medico-Chirurgical Transactions (London, 1809), vol. i., p. 197.

[11] American Journal of the Medical Sciences (July, 1841), p. 105.

[12] Transactions of the Clinical Society of London, vol. vii. 1874, p. 105.

kind of paralysis (the direct) than the other. We are led to a similar conclusion, and with much more force, when we compare the cases of cross paralysis due to a tumour pressing on the antero-lateral surface of the pons Varolii and on the anterior surface of the crus cerebelli, of the cerebellum, and sometimes also of the medulla oblongata. The best of the cases I know of tumours located in that place having caused a cross paralysis are those published by Dr. T. C. Allbutt,[13] Bouvier,[14] Dr. Bright,[15] Duguet,[16] Féréol,[17] Friedreich,[18] Drs. Gairdner and Haldane,[19] Jobert de Lamballe,[20] Leyden,[21] Dr. J. W. Ogle,[22] Professor Rosenthal,[23] Rühle,[24] Salter,[25] Tessier.[26] In those cases, as well as in the cases from similar lesions producing direct paralysis (see THE LANCET, Sept. 27th, p. 452), the tumour had its centre at the place of origin of the fifth nerve, or between that point and the crus cerebelli. In either of the two sets of cases we find that sometimes the pressure was slight, and produced only superficial alterations of the pons and crus cerebelli. In either set also we find that, on the contrary, the tumour often extended as far down as the lower part of the medulla oblongata on its side or on its anterior pyramid, and as far up as the crus cerebri. Between these two dimensions (small or very large) there were, in the two sets of cases, tumours of intermediate sizes. In some of the cases the pressure was chiefly on the lateral parts of the pons; in other cases the principal alteration was in the supposed motor tract in the pons, and sometimes also in the crus cerebri and the medulla oblongata. Facts of those various kinds are found in the group of cases of direct as well as in that of cross paralysis. The point most worthy of attention is that the number of cases of alteration of the so-called motor tract producing direct paralysis was notably larger than the number of cases of similar lesion causing cross paralysis.

It is clear, therefore, that the views that are admitted as regards the mode of origin of paralysis in cases of disease of the pons Varolii and medulla oblongata, and as regards the channels of transmission of the orders of the will to muscles through those parts, must be rejected.[27]

Clinical Lecture
ON A
CASE OF RENAL CALCULUS.

Delivered at St. George's Hospital,

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GENTLEMEN,—The case to which I propose to draw your attention to-day is one of renal calculus—that is to say, stone lodged in the pelvis of the kidney. In the particular instance before us there were, in fact, *two* stones, and we were enabled to diagnose their presence with absolute certainty, by the fact that we could, by rubbing them together, elicit distinct grating—a point of no little importance, for, as I shall have occasion to show you, the diagnosis in these cases is by no means certain, and instances have occurred in which the presence of a calculus in the pelvis of the kidney has been determined on, an operation for its removal performed, and no stone found. For the notes of the case I am indebted to my clinical clerk, Mr. Bulteel.

Anne R——, aged forty-four, a married woman, was admitted into Harris ward under the care of Mr. Pick. She stated that she had had two children. Her father and mother both died of asthma; one sister died of phthisis; one brother has also died, but she does not know of what disease. Some years ago she began to experience great pain in the left loin, which was very violent and too "bad to explain." Soon afterwards matter began to come away in her urine, and has continued to do so ever since. The pain is not now so bad as it used to be; it comes on in paroxysms about every five minutes, and is of a "shooting" character and extends from the left loin down to the region of the bladder, but is not accompanied by a desire to pass water. She has never noticed any blood in the urine. The catamenia are not regular.

Upon admission she was found to be an emaciated subject, and had an anxious expression of countenance; the pulse was 102, weak and thready; the heart-sounds normal; the face pale; the tongue white and œdematous. The pain is described as extending from the left loin down to the hypogastric region, and thence to the vulva, but does not extend down the inner side of the thigh. It is not increased by moving about, but is equally severe when she remains quiet in bed. She generally requires to pass her urine every two hours, and the desire to do so is not greater or more frequent when she is up than when she is in bed. In the left lumbar region, at about a level with the spine of the first lumbar vertebra, a hard mass can be felt. This can be best perceived from behind, between the last rib and the crest of the ilium, firm pressure being made on the front of the abdomen so as to push the mass backwards. It is of about the size and shape of a sheep's kidney, but appears to be made up of two if not more lobules. It is freely movable and very hard. On one occasion, upon examining it, a slight grating was thought to be felt. The urine is thick and cloudy, and about one-fourth of its volume is pus. It contains no crystalline deposit and no blood.

A day or two after admission she was placed under the influence of ether, in order that a more careful examination of the mass might be made. It was then easily felt to consist of two hard, rounded substances, which could be moved on each other, and on doing so a distinct grating was perceived. The patient absolutely refused to entertain the question of any operation, and, at her own request, was discharged.

Such, gentlemen, was briefly the history in this case, and you see from the peculiar circumstance of there being two stones, and that they could be moved on each other, thus producing a grating, we had no difficulty in arriving at a diagnosis. Had it not been for this fact, however, the difficulties in arriving at a determination as to the exact nature of the case would have been great, for there were several features in it which would have tended to throw us off our guard or on a wrong scent; and I would desire, therefore, in the first instance, to say a few words on the symptoms to which stone in the pelvis of the kidney gives rise before proceeding to discuss the operation which has been proposed, and, in some few instances, performed for its relief.

As, no doubt, all of you are aware, calculi may originate either in the kidney or in the bladder, and they are formed in consequence of some peculiar state of the system, or diathesis, as it is generally called. And of these diatheses there are three principal forms, in addition to some other uncommon forms, of which it is not necessary at present that I should say anything: the lithic-acid diathesis, the oxalic, and the phosphatic. Now it may be taken as a broad rule, to which, however, of course, there may be exceptions, that when a calculus originates in the kidney the nucleus is either of lithic-acid or oxalic-acid formation; whereas, on the other hand, if the stone is formed in the first instance in the bladder, the nucleus is either phosphatic or consists of some foreign body in the bladder, probably introduced into that viscus from without. All renal calculi may be said, therefore, to be constitutional and to arise from some morbid state of the urine, this state or condition depending on malassimilation. Now, when a stone forms in the pelvis of the kidney, it may either remain there, or it may pass down the ureter into the bladder. If it remains,

[13] Transactions of the Pathological Society of London, vol. xix. 1868, p. 20.
[14] Gazette Médicale de Paris, 1840, p. 430.
[15] Guy's Hospital Reports (London), vol. ii. 1837, p. 286.
[16] Bulletins de la Société Anatomique (Paris, 1865), p. 496.
[17] Id. Id. Id. (Paris, 1857), p. 111.
[18] Beiträge zur Lehre von den Geschwülsten inherhalb der Schadelhohle (Würzburg, 1853), two cases, pp. 15 and 29.
[19] The Edinburgh Medical Journal (March, 1861), p. 795.
[20] Etudes sur le Système Nerveux (Paris, 1838), p. 456.
[21] Klinik der Rückenmarks-Krankheiten (Berlin, 1875), vol. ii., p. 154.
[22] Transactions of the Pathological Society (London, 1854), vol. v., p. 26.
[23] Traité Clinique des Maladies du Système Nerveux. Traduction Française (Paris, 1878), p. 210.
[24] Quoted by Ladame: Symptomatologie u. Diagnostik d. Hirngeschwülste (Würzburg, 1865), p. 255.
[25] Edinburgh Medical and Surgical Journal, vol. xi., p. 470. Quoted by Abercrombie: Patholog. and Practical Researches on Diseases of the Brain, fourth edition (Edinburgh, 1845), p. 450.
[26] Bulletins de la Société Anatomique (Paris, 1834), p. 171.
[27] In a very learned work of Professor H. Nothnagel, which I have just received ("Topische Diagnostik der Gehirnkrankheiten," Berl., 1879), I have vainly looked for new cases of cross or direct paralysis due to disease of the medulla oblongata. Only a few of the cases I have quoted are mentioned. It is indeed a most remarkable fact that a part of the cerebro-spinal centres so often diseased as is the medulla oblongata, is so rarely the cause of hemiplegia or of paralysis of one limb.

one of several things will happen: either it will grow, extending into the ureters and calyces, gradually causing absorption of the substance of the kidney, producing excessive pain and irritation, and eventually death from exhaustion; or, on the other hand, it may grow, but without producing any irritation, and its presence may not even be suspected until the post-mortem examination, the patient in the meantime having died of some other disease. For instance, I show you this beautiful specimen[1] from our museum, in which the kidney is one mass of stone. The "cortical and tubular portions have been completely absorbed, nothing of the organ remains, excepting the thickened external capsule and the projecting fibrous septa, which form a number of large sacculated cavities communicating with each other." And yet the presence of the stone was not suspected during life, and the patient was admitted into the hospital for quite another disease—typhoid fever, I believe, from which he died. So, again, here is another specimen in which the same thing has occurred. In other cases a stone lodged in the pelvis of the kidney may gradually mould itself to the form of the cavity in which it is contained, and, eventually blocking up the ureter, may produce suppression of urine. I show you here two kidneys, in which the orifices of the ureters are obstructed by calculi. They are not impacted, but lie in the funnel-shaped orifices, which they are polished to fit, so as to close them accurately. The preparation was taken from the body of a man forty-nine years of age, who died in the hospital, having for twelve days had incomplete suppression of urine.[2] Lastly, a stone in the pelvis of the kidney may give rise to suppuration in and around that organ, the abscess may point externally in the lumbar region, and the stone be discharged through the opening thus formed.

Let us now consider the symptoms by which we should recognise the presence of a stone in the kidney:—First, there would be pain, and sometimes very great pain, in the loin, and, as in our patient, extending down to the hypogastric region and the genital organs. This pain would in some cases be much increased on moving about; so that—just as we find in stone in the bladder—the patient is comparatively easy so long as he remains perfectly quiet in the recumbent position; but if he moves about, and especially if he takes carriage or horse exercise, the pain becomes unbearable. I apprehend that the presence or absence of pain, and of this peculiar characteristic of it—its increase on movement,—depends in a great measure upon the size of the stone. If the stone is small, lying loosely in the pelvis of the kidney, it will be jolted about with the movement of the body, and thus, striking against the lining membrane of the cavity, it causes irritation, and so pain; if, on the other hand, the stone is large, it becomes more or less fixed, and, as we have seen, moulded to the space in which it is contained, and therefore it does not move with the various motions of the body, and the jarring or concussion, and hence the pain, is prevented. You will have noted that in our patient the pain was "*not* increased by moving about"; but then you must remember that the stone was large, so large that it could be felt as a distinct lump through the abdominal wall, and no doubt moulded to its cavity. Again, the nature of the stone will have something to do with the amount of pain. The rough, tubercular, mulberry calculus would necessarily cause more irritation than the smooth lithic-acid stone. Another symptom would be hæmaturia—blood in the water,—and this is of considerable importance. As you all know, bleeding may take place from any part of the urinary tract, but when it comes from the kidney it presents certain differences by which we can at once recognise its source. The blood is then intimately mixed with the urine, which presents the appearance of ordinary coffee, and in addition to this we often find blood-casts of the urinary tubules, which is, of all, the most certain sign, though, of course, less likely to be present in cases where the blood comes from the *pelvis* of the kidney.

Bleeding from the kidney may arise from—(1) Rupture or laceration; (2) congestion from nephritis or the use of certain drugs; (3) from a peculiar form of disease, which has been termed "intermittent hæmaturia"; (4) from cancer and other tumours; and (5) from calculi. Putting out of consideration the first three causes, in which our diagnosis would be sufficiently obvious, we must say a word or two upon the way in which we should determine whether, in a case of renal hæmaturia, the source of the blood was from the presence of a stone or from malignant disease in the organ. Without adverting to the ordinary points, such as the history of the patient, his constitutional diathesis, and his general appearance, all of which, nevertheless, would form important elements in our diagnosis, let me draw your attention to one particular circumstance, which I well remember used to be much insisted upon by the late Dr. Bence Jones when he was physician to this hospital. He used to teach that in bleeding from the kidney, when from malignant disease, the blood would be greatest in quantity when the patient was warm and quiet in bed, whereas if the cause of the blood was a calculus, the bleeding would be greatest when the patient was up and about. When confined to bed the surface of the body is warm, and more blood is sent to the internal organs, and hence the greater quantity of blood in cases of cancerous tumour; whereas, as we have seen, in stone in the kidney, when the patient is moving about, it knocks or jolts against the wall of the cavity, and so by mechanical injury produces the hæmorrhage. You will remark that in the case the notes of which I have read to you there was no blood in the urine, and in this way I think we may explain the fact; as I have just stated, the bleeding is produced by mechanical injury, and in this case, the stone, being large, was more or less moulded and fixed, and so this injury did not take place.

Another symptom which we should have in calculus of the kidney, and which would afford us an important aid in diagnosis, would be the presence of pus in the urine. As we have just seen, the disease with which it is most likely to be confounded is malignant disease of the kidney in its early stage. In fact, the late Dr. Basham, in his work on Diseases of the Kidney, states "that malignant disease can then hardly be distinguished, except, perhaps, by its antecedents, from calculus of those organs." Now, in the presence of pus in the urine we have an important means of diagnosis. In the early stage of malignant disease there is no pus. A patient afflicted with this affection will be liable to repeated hæmaturias, with intervals of rest, during which the urine becomes clear, apparently free from blood, and *contains no pus*. In calculous disease, on the other hand, even when the disease is in a quiescent stage, and the urine contains no blood, it will be found to be turbid and milky, and deposit an abundance of sediment, the purulent nature of which will be revealed by the microscope. I ought further to mention that Mr. Bryant insists much on the fact that the urine contains *pus*, and not *mucus*, as evidence that the morbid secretion comes from the kidney and not from the bladder.[3]

We come now, however, to what appears to me to be the most important sign, and that is the possibility of being able to feel the stone. And there are two ways in which an attempt may be made to do this, either through the abdominal wall or by the rectum. Of course, the first, being the simpler measure, should be first tried, but failing to feel the stone in this way, I see no objection to introducing the hand into the rectum, and by this means reaching and exploring the pelvis of the kidney. I have no personal experience of this proceeding myself, but many of you may remember a patient in Fuller ward some twelve months or so ago, in whom Mr. Holmes introduced the whole hand into the rectum without any difficulty. In Holden's "Landmarks"[4] Mr. Walsham states that he has been able in some instances, by introducing his hand into the rectum, to reach the lower half of the left kidney. And he makes the remark: "Probably the existence of a calculus in the kidney might be detected." It is scarcely necessary to remark that this mode of investigation could only be employed when the disease was suspected to exist on the left side. In our patient it was not necessary to employ this means, because we were quite satisfied as to our diagnosis without; had we not been so I should not have hesitated to adopt it. The best means, however, because the simplest, is to endeavour to feel the stone, by palpation, through the abdominal wall. And if the patient is somewhat emaciated, as in all probability he will be, and the stone is of any considerable size, there is not much difficulty in detecting it. It is better to administer some anæsthetic in order to do away with the resistance of the abdominal muscles, and to empty the lower bowel by means of an enema. The patient then lying on his back, firm pressure is made on the front of the abdominal wall, and the stone, if it exists, will be felt in the loin, between

[1] Vide St. George's Hospital Museum Catalogue, Ser. xi., No. 47.
[2] See Path. Soc. Trans., vol. xiv., p. 192.
[3] See THE LANCET, July, 1870.
[4] Landmarks, Medical and Surgical, page 71.

the last rib and the crest of the ilium, about the level of the spine of the first lumbar vertebra. It will seldom happen, I imagine, that we shall get such a certain means of diagnosis as we had in the case under consideration, where we had two stones in contact, and by moving them on one another produced a grating which could not be mistaken for anything else.

These, then, gentlemen, are the principal points by which you would be guided in arriving at your diagnosis in cases of calculus in the kidney. And now, having determined in your own mind that a stone exists, the question arises, what course are you to pursue? The medical treatment in these cases is unsatisfactory, and can at the best be only palliative. The only plan which holds out any hope of permanent cure is to remove the stone by operation. But are we justified in performing what must be regarded as a very formidable and serious operation for the relief of this affection? I think the answer to this question must depend upon the amount of irritation which is set up by the stone. We have already seen that in some cases the stone may remain perfectly quiescent for years, and without producing the slightest disturbance. If the presence of a stone under such circumstances were detected, I imagine no surgeon would advise its removal. Then, again, as Dr. Owen Rees has pointed out, stone in the kidney may after a time become encysted, and a patient gradually obtain relief of his symptoms.[5] So that in cases where the symptoms are not very urgent, and have not existed for any length of time, it would, I imagine, be unwise to operate, but would rather be desirable to wait in the hope that the calculus might become encysted. It seems to me that we should confine our operation to those cases where there is a marked and progressive deterioration of the general health. Where, in fact, the patient is becoming worn out by the constant pain and drain on his system from the hæmorrhage or discharge of pus from his kidney. Even in our patient, where these symptoms were present to a certain extent, I did not feel justified in pressing the operation upon her. It was right, considering she was emaciating, that she was suffering constant pain, that her nights' rest was frequently disturbed by calls of nature to pass water, and that she had a considerable discharge of pus going on, that she should be informed that an operation could be performed for her relief. But, on the other hand, it had to be borne in mind that these symptoms had existed for some years, and that in all human probability they might go on, perhaps even diminishing in severity, for some years longer, whereas if she submitted to an operation her life might be terminated in a few hours. Accordingly, I did not, as I have said, feel justified in pressing the operation upon her, and I am not sure that she did not act wisely in refusing it, and that, had I been in her place, I should not have acted in the same way as she did.

I do not propose to say anything to you about the history of the operation of nephrotomy, further than remarking that it is as old as Hippocrates himself, but would refer you to an interesting paper by Mr. Thomas Smith in the Medico-Chirurgical Transactions, in which he enters fully into the history of this operation, and which I should advise you all to read.[6]

The operation of nephrotomy for removal of a calculus from the pelvis of the kidney has not hitherto been attended by much success. In modern times I do not know of any case in which the operation has been successfully performed. Though in the nineteenth volume of the Philosophical Transactions, as mentioned by Mr. Smith, there is an account of a case in which one Dominicus de Marchetti, a physician of Padua, removed two or three small stones from the kidney of the English consul at Venice, with such success that his pain was at once relieved, and ten years afterwards he was enabled to "undergo as much fatigue as any man of his years, and was able to ride post forty or fifty miles." Again, in the first volume of THE LANCET for 1874 is a short note stating that in the *Gentleman's Magazine* for August, 1733, is an account of a case in which a surgeon name Paul, of Stroud, in Gloucestershire, successfully extracted a stone as big as a pigeon's egg from the kidney of a woman.

I have only been able to find the record of two cases, in modern surgery, in which a stone has been diagnosed in the pelvis of the kidney, and in which it has been extracted; and in both these cases the patient succumbed to the operation. In the *American Journal of Medical Science* is an account of a case in which Mr. Whittaker removed a calculus from the pelvis of a kidney.[7] The patient had suffered from symptoms of stone for eight years. The operation was performed by a vertical incision from the tip of the eleventh rib to the crest of the ilium, and a stone one scruple in weight and nearly an inch long was removed. The patient died of pyæmia on the fifth day. Mr. Holmes, in his work on Surgery, mentions a case in which Mr. Callender removed a calculus from the pelvis of the kidney, but he also states that the patient died.[8]

You will see therefore, gentlemen, that the operation is one fraught with danger to the patient, and one not lightly to be undertaken, or without making your patient fully aware of the risk he must run. Nor, as I have said before, is the diagnosis devoid of difficulty. In THE LANCET for 1870 you will find an account of a case in which Mr. Bryant performed the operation of nephrotomy and found only a bag of pus, the patient dying on the twenty-fifth day after the operation from peritonitis.[9] And in the *Medical Times* for the same year is an account of a case in which Mr. Durham also performed nephrotomy, and found no stone.[10]

And now, before we conclude, let me say one word or two upon the operation itself, and they must be very few, as our time has almost expired. Of course, I need scarcely tell you that the operation is to be performed in the loin, so as to open the pelvis of the kidney from behind, and thus avoid wounding the peritoneum. Mr. Bryant recommends an oblique incision, Mr. Thomas Smith a longitudinal incision, from the last rib to the crest of the ilium, along the outer border of the erector spinæ. I do not know whether there is much to be said in favour of the one over the other; though I think on the whole I should give the preference to the oblique incision, as in this way you would cut across the line of the kidney, and thus be sure to find the pelvis of the organ in some part of your incision, instead of cutting in front or behind it, as you might do with the vertical one. Not that I think this is a matter of any great importance. I imagine that there would be no difficulty experienced in reaching the pelvis of the kidney either by the one incision or the other. The skin, fasciæ, and various layers of muscles having been divided, the transversalis fascia must be carefully incised on a director, and this would expose the fascia surrounding the kidney, which must be laid open, and thus the hilum of the kidney exposed to view. The stone should now be sought for, and if it can be felt in the pelvis and dilated extremity of the ureter this must be freely cut into, and an attempt made to extract the stone. The great point to avoid would of course be the wounding of the kidney structure, which might be attended with severe and uncontrollable hæmorrhage. So long, however, as you can confine your cutting to the walls of the dilated extremity of the ureter, the amount of bleeding would in all probability be small, and not sufficient to cause any anxiety on your part. The chief point in the after-treatment of your patient would be to take care that he was kept constantly lying on his back, in order to permit the free exit of urine through the external wound, and thus to avoid, if possible, the dangers of extravasation of that fluid.

[5] Croonian Lectures on Calculous Disease and its Consequences, p. 40, 1856.
[6] Med.-Chir. Trans., vol. liii., p. 211.

THREE CASES OF EMPYEMA.

By CHRISTOPHER ELLIOTT, M.D.,
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CASE 1.—F. R——, aged nine, the son of a sawyer at Abbott's Leigh, was admitted into the Children's Hospital under my care on April 6th, 1877, with pleuro-pneumonia of the left side. His illness had begun five weeks previously, and was pronounced to be inflammation of the lungs with bronchitis by the medical man in attendance. The patient's condition on admission was as follows:—He was hectic-looking, thin, and breathing in a hurried and jerky manner, the respirations being 52 in a minute. The body was bathed in profuse perspiration; there was a short dry cough, and orthopnœa, but no history of hæmoptysis; the tongue was

[7] American Journal of Medical Science, vol. lxv., p. 279.
[8] Surgery, its Principles and Practice, p. 732.
[9] THE LANCET, vol. ii., July 2nd and Aug. 27th, 1870.
[10] Medical Times and Gazette, 1870, p. 61.

dry and fissured; the pulse quick (120) and feeble; temperature 101·4°. Physical examination of the chest revealed, on the left side, absolute dulness upon percussion both anteriorly and posteriorly, faint respiratory murmur, diminished vocal fremitus, and the heart's apex displaced slightly to the right of the left nipple; on the right side there was clear resonance both in front and behind, and puerile breathing. On account of his extremely weak condition, he was ordered a mixture of carbonate of ammonia, to which tincture of belladonna was added in order to allay both the cough and perspiration.

On April 9th he was able to lie down, and the cough and perspiration had diminished. He had now diarrhœa, the motions being loose, of a yellow colour, and having a very offensive smell. On the 14th the diarrhœa had quite ceased, but for a few days he had been in a very drowsy condition, sleeping a great deal. On the night of the 13th he passed a round lumbricoid worm, about seven and a half inches long; on the 16th six more, and on the 17th two more.

On April 30th a tumour was noticed for the first time in the left side between the sixth and seventh ribs. There was distinct fluctuation in it, and the skin looked red, thin, and as if it would be likely soon to give way. Temperature 98·4°. The tumour was diagnosed to be an empyema pointing externally.

On May 1st an incision was made under the carbolic spray, and about two ounces of healthy pus let out. A drainage-tube was then put in, but as it was being introduced the spray apparatus got out of order and ceased to work. Lint steeped in carbolised oil was employed as dressing, and a layer of cotton-wool placed over this. On the following day the opening was enlarged as very little pus had been discharged, but there was no material increase in its flow. On the 8th the tube was taken out, and pig. iodi ordered to be painted over the left side.

May 17th.—There was a very free discharge of pus this morning, and also a return of hectic symptoms. At my request my colleague Mr. Ewens kindly opened the thorax between the ninth and tenth ribs just below the inferior angle of the scapula, according to the plan of Bowditch, of America. The drainage-tube was passed through both openings and a poultice applied.

18th.—The pleural cavity was freely discharging, but the pus flowed almost entirely through the upper and older opening. The poultice was left off, and carbolised tow alone used as dressing.

25th.—The tube was taken out, and not reintroduced. The discharge of pus still continued to be very free.

27th.—The patient was attacked with acute bronchitis. Moist râles could be heard all over the chest on both sides, both in front and behind, and there was copious expectoration of glairy frothy mucus.

On June 6th he began to whoop. On the 10th he was delirious during the night. On the 16th he passed another round worm quite a foot in length. This was the tenth lumbricoid he had voided during his stay in the hospital.

On the 23rd he had greatly improved. The bronchitis and whooping-cough had left him, the pleural cavity had ceased to discharge for some days, and he was daily gaining flesh. Physical examination of the chest showed that the dulness was still well marked over the left side, but the heart had returned to its normal position, and the respiratory murmur was quite audible all over the left lung except at the base, where it was rather faint. On July 7th he was discharged cured.

CASE 2.—E. S——, aged three years and a half, the child of a draper's assistant in Bristol, was admitted under my care on July 10th, 1877, for left empyema. She had been ill about a month, but her parents had not sought for medical advice before. As I was away from home when the patient came into hospital, the house-surgeon, Mr. J. R. Lewis, M.B., drew the attention of my colleague, Mr. Ewens, to the case, who, after consultation with the other members of the staff, decided to open the pleural cavity at once, as the breathing was very quick and embarrassed, and there was absence of respiratory murmur in the left lung, with well-marked dulness upon percussion over the left side, and displacement of the heart beyond the line of the right nipple.

The patient was put under the influence of chloroform, and Mr. Ewens made an opening under the carbolic spray between the tenth and eleventh ribs, slightly posterior to the mid-axillary line. About four ounces of pus were evacuated, which gave almost immediate relief to the urgent symptoms. The wound was dressed antiseptically, and the patient was put on beef-tea and milk and a mixture of bark and iodide of potassium. Next day a drainage-tube was put in under the carbolic spray. On July 13th the dressings were removed in the evening. There was a very free discharge of pus. The patient seemed brighter, and breathed quietly. The temperature was normal. On July 15th the wound was again dressed, and the pus was found to be flowing freely through it. On the 16th the patient was ordered cod-liver oil and hypophosphite of lime.

At the time of my visit, on the 18th, I found that in consequence of the child constantly wriggling about in bed, the dressings had slipped from over the opening into the thorax, and left it exposed to the air. However, no harm seemed to have resulted, and I simply placed a pad of lint soaked in carbolised oil on the opening, and over that a layer of oakum to absorb the pus, which was flowing very freely, and was of a healthy character.

On July 21st the tube was taken out. On the 28th the flow of pus had considerably diminished in quantity, and on Aug. 9th it had ceased; but on Aug. 13th it began to flow again just as freely as at first, and it continued to do so more or less freely till Sept. 3rd, when it ceased entirely, and the opening rapidly closed.

On Sept. 19th the patient was transferred to the convalescent ward, but next day she was attacked by measles. She however, went through it without sustaining any harm, and was discharged well on Oct. 6th, 1877.

CASE 3.—F. H——, aged five, whose father is a warehouseman living in a suburb of Bristol, was admitted under my care on Oct. 4th, 1878, for a swelling in the right mammary region, in which only an indistinct sense of fluctuation could be obtained immediately above the nipple. The patient had pleurisy five months ago, and the swelling was noticed for the first time about a fortnight since, but during the past three or four days it had become more prominent. The patient was very thin and emaciated (weight twenty-six pounds); she was hectic-looking, felt sick, breathed rapidly, had a cough, and the tongue was coated with a thick fur which had a red stripe down the centre. The temperature was 98·8°; the urine was straw-coloured, slightly acid, contained no albumen, and was of a specific gravity of 1028. Physical examination of the chest revealed on the right side dulness upon percussion both in front and behind, and feeble respiration, while there was on the left clear resonance and puerile breathing. As I had to go out of town next day, my colleague, Dr. A. Steven, kindly took charge of the case, and on the 17th he requested Mr. Ewens to explore the pleural cavity with a grooved needle, which was passed in at the sixth intercostal space in the mid-axillary line, and as pus was met with a trocar was thrust in at the same opening, and four ounces of pus were let out. Next day the breathing was distinct behind, but feeble and distant in front, and there was some creaking from air having got in and caused emphysema.

On Oct. 23rd, at my request, Mr. Ewens introduced a trocar at the seventh space, and ten ounces of pus came away. After this the emphysema was less marked; and on the 28th, when the patient's weight was taken, it was found to be 28½ lb., which was a gain of 2½ lb. since admission. As, however, the pus had reaccumulated, and I could distinctly feel it below the clavicle between the ribs, on Nov. 4th I requested Mr. Ewens to enlarge the former opening with a knife and insert a drainage-tube. He kindly did so, and about four ounces of pus came away at the time of the operation. The carbolic spray was not employed, because I did not see the necessity for it, as air had got into the pleural cavity at the first tapping. On the 9th the emphysema had completely disappeared, but the pus continued to flow persistently for the next two months. The patient nevertheless gained flesh, for her weight on Dec. 3rd was 30 lb., and on Jan. 11th 33 lb. On Jan. 1st the drainage-tube was taken out, and a few days after the opening closed. On the 15th she was sent to the convalescent ward, and on Feb. 2nd she was discharged well, the breath-sounds being clearly heard in every part of the right lung, although decided dulness still remained over that side. Her diet was throughout generous, consisting of milk, eggs, fish, fowl, and meat. Her medicine consisted of tonics, quinine and iodide of potassium, and cod-liver oil. Her temperature was never

high, and only on two occasions rose as high as 102·6°, and these were the evenings of Oct. 21st and 30th.

Remarks. — In the treatment of empyema the different surgical methods which have been suggested and put into practice may be grouped into three divisions: 1st, that of aspiration; 2nd, that of tapping; and 3rd, that of incision.

1st. Aspiration has been pretty generally tried, but I think it has not accomplished the amount of good that was anticipated at one time would result from its more extended use. On the few occasions I have seen it employed in this class of cases I must say I was not favourably impressed by it, as the needles became blocked by flakes of lymph, which were mixed with the pus. Fraentzel says he has overcome this difficulty without rendering it necessary to reintroduce the trocar by the construction of a trocar with a lateral tube and stylet. The stylet in the cannula is drawn back only so far as to clear the aperture of this lateral tube, and may at any moment be thrust forward again, and thus the fluid flows away by the lateral aperture. A full description of his instrument is given in Ziemssen's "Cyclopædia of the Practice of Medicine," vol. iv., p. 704.

2nd. Tapping by means of a trocar and cannula appears at first sight to be all that could be desired, as the relief given to the patient's urgent and distressing symptoms is so striking; but, except in cases where the pus is confined in a limited and circumscribed region by adhesions, a cure is seldom effected; and the operation has usually to be repeated again and again as the fluid more or less quickly reaccumulates, and in the end an incision has to be made.

3rd. The method of making a free incision into the pleural cavity is finding increased favour, and, although my experience is too limited to allow me to dogmatise, it is a procedure to which I give a decided preference, and which I have pursued in the cases related above. It is based on true scientific and surgical principles. We see nature adopting it when an empyema points and discharges itself, either externally, or internally through the lung-tissue into the bronchi, and the patient recovers; and we have a further illustration in surgical practice where surgeons are wont to make a free incision into an abscess, as we know with the best result. Why then should we adopt a mode of treatment for a collection of pus in the pleural cavity differing in no respect from that in another part of the body, where it is the result of acute inflammatory action? Fraentzel, to whom I have alluded before, truly remarks: "It is on account of these sad experiences of exhausting purulent fever, years of failing health, &c., taken in connexion with the fact that puncture in purulent effusions but very rarely leads to recovery, that what is called the 'radical operation'—that is, the withdrawal of the pus by means of an incision into the pleural sac—has come more and more into favour." After describing the way in which he performs the "radical operation," he concludes thus: "It is the therapeutic method which I regard as the most rational, and with which I have obtained the best results."

With regard to the question *where* we ought to make the incision, there will of course be a divergence of opinion, founded on different experiences; but nearly everyone will agree that in the case of an empyema pointing externally, the incision should be made there. When, however, there is no such indication, I believe it will be better to make the incision in the mid-axillary line, in either the fifth or sixth intercostal space on the left side, and in the sixth or seventh on the right side. Bowditch (of America) has recommended the ninth space, just below the inferior angle of the scapula; but, as Fraentzel observes, there are likely to be thick adhesions there, and in one case in which I tried it I found that the pus came more freely through a former opening which had been made in the mid-axillary line, notwithstanding that the latter was the higher of the two openings. Another reason I believe is, that patients with pleuritic effusions do not lie altogether on their backs, but rather more on the affected side, in order as much as possible to lessen the pressure of the fluid on the lung, and so the higher opening becomes the more dependent. The employment of the carbolic spray at the time of operation and when the dressings are removed decidedly lessens the risk of septicæmia, pyæmia, &c.; but these are evils which I am inclined to attribute rather to the fact of the pus being unable to escape than to that of the air entering the pleural sac, and it is on this account that a large opening should be always made. All the dressing necessary to employ is oakum.

Redland, Bristol.

REMARKS ON CELLULITIS OF THE NECK
(ANGINA LUDOVICI).

BY ROBERT WILLIAM PARKER,
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PHLEGMONOUS CELLULITIS of the neck is not by any means a common disease. As cases of the kind have recently come under my own observation, I have thought that a short account of them, together with a few remarks, might not be out of place.

CASE 1. *Gangrenous cellulitis of the neck; spontaneous onset; asthenia; death.*—Charlotte R——, aged two years, was brought to me as an out-patient at the Children's Hospital on Nov. 16th, 1877, suffering from an inflammatory œdema of the front of the neck; it extended from the chin as low down as the sternum. The mother stated that the child had been very ill some weeks previously. She (the mother) thought that the child might have had measles, but as there had been but little rash she was not certain. (Measles was epidemic in this district at this time.) When first seen the front of the child's neck presented a brawny induration; the skin was slightly reddened, and the part pitted slightly on pressure. The brawniness involved the front of the neck between the two sterno-mastoid muscles, and extended from the chin to the sternum. Although its margins were not absolutely defined, the swelling was nevertheless well localised. The disease had come on quite suddenly. The mother, on being asked, did not think that the glands behind the angles of the jaw had been previously enlarged before the general œdema had supervened. She could not tell me at what point it had first commenced. The fauces and mouth presented nothing abnormal. The breathing was not embarrassed, nor was swallowing interfered with. The mother refused to leave the child in the hospital. Incisions were therefore made at one or two points where suppuration was suspected, but without finding pus. At the next visit the child was much lower. There had been a free discharge of a stinking ichorous pus, and several large sloughs had come away. The child was now left in the hospital. Brandy, ammonia and bark, milk and eggs were freely administered, but the child rapidly sank.

The autopsy revealed extensive lobar pneumonia of both lungs. Heart and pericardium normal. Abdominal viscera also normal. The muscles in front of the neck (sterno-mastoids and the depressors of the hyoid bone) were all exposed down to their origins, and looked as though they had been dissected.

CASE 2. *Glossitis (so-called); abscess in the supra-hyoid region, with general inflammatory œdema of the neck, especially on the left side; rapid onset; rapid subsidence; recovery.*—John K——, aged twelve and a half years, was admitted on Sunday, September 8th, 1878. On the previous Thursday evening (up to which time he had been quite well) a "small lump" was noticed by his mother below the jaw on the left side. This increased in size, and on the Saturday following he was first seen at the hospital in the casualty room. He had then what appeared to be an ordinary abscess forming in the neck. He was seen again on the following day (Sunday) at 10 A.M., and was found in much the same condition. He remained so until 4 P.M. At this time he began to complain of his tongue, which was swelling; by 6 P.M. (that is, in the course of about two hours) his tongue was swollen to quadruple its normal size, so that it protruded from his mouth, which was no longer large enough to hold it. He was brought to the hospital a second time, and was admitted about 10 P.M.

His condition on admission, as noted by Mr. Hutton, assistant resident medical officer, was as follows:—There is considerable swelling below the jaw on the left side, and to a less extent on the right side; no distinct fluctuation can be made out; there is great œdema. The cheeks are a little swollen. The tongue is very much swollen, red, and tense, protruding between the teeth, and preventing closure of the mouth, which is open to its full extent; the swelling is confined to the front part of the tongue. Large quantities of thick, glairy saliva were being spat out.

On Sept. 9th, the breathing having become more uneasy, it was determined to explore the neck. An incision was

made at the most likely place, but pus was not reached. Towards evening, the temperature being 103·2° F., and there being great distress, the tongue was freely incised on either side of the median line by Mr. Hayward, the resident medical officer. This gave considerable relief within a short time.

On the 11th the swelling had somewhat subsided, but the notes state "it is still swollen and hard; there is no fluctuation." The notes continue: "On raising the tip of the tongue, pus can be seen issuing at the point where the mucous membrane is reflected from the tongue to the floor of the mouth, and a probe can be passed in, downwards and backwards, for three or four inches. The swelling on the outside of the jaw still persists. It is hard and brawny, pits slightly on pressure; but no sense of fluctuation can be obtained at any point. The rest of the mouth seems healthy. The enlargement does not involve the posterior part of the tongue."

On the 13th, about midday, the tongue suddenly began to subside. At 10 A.M. it was only about one-third its previous size. This rapid subsidence was not accompanied or preceded by any discharge of pus, or other process which would explain it.

On Sept. 14th the neck was again incised, and pus was this time "struck" and let out. On the 18th the tongue had quite subsided to its normal proportions. Convalescence now rapidly advanced.

CASE 3. *Inflammatory œdema, leading to abscess, in the submental and subhyoid regions of the neck; inflammation of the genio-hyo-glossus muscles, and abscess.*—James W——, aged seven, was brought to the hospital on October 29th, 1878, with a little patch of brawny inflammation beneath the chin and over the hyoid bone. The mother stated that the boy began to complain of "toothache" three weeks ago. She remarked that his tongue "was fixed," so that he could not put it out. There was a slight discharge from beneath it. On examining I found the floor of the mouth was hard, red, and painful, and that from a small hole on the right side of the frænum, which passed downwards and forwards to the hyoid bone, there was a discharge of thin pus. The tongue was fixed, and could not be either put out of the mouth or moved from its place. Its general appearance, however, was quite normal. The pharynx was normal. The boy's general health was but little impaired. The induration in the neck gradually softened, and was incised and pus let out. The symptoms in the mouth then quickly subsided, and the boy soon recovered. The movements of the tongue, however, are still considerably limited.

In looking up the history of this disease, it is obvious that it was known to the earliest writers. Thus, Aretæus,[1] in his chapter on Angina or Quinsy,' says: ..... "Cases of cynanche are attended with inflammation of the tonsils, of the fauces, and of the whole mouth; the tongue protrudes beyond the teeth and lips; they have salivation, the phlegm running out very thick and cold; they have their faces ruddy and swollen; their eyes protuberant, wide open, and red; the drink regurgitates by the nostrils. The pain is violent, but obscured by the urgency of the suffocation; the chest and heart are in a state of inflammation. ..... In certain cases there is a ready transference of the disease to the chest, and these die from the metastasis. ..... But if, in any case, there is a turn to the better, abscesses form on either side, near the ears externally, or internally about the tonsils. ..... This species is called cynanche, either from its being a common affection of those animals, or from its being a customary practice for dogs to protrude the tongue even in health. The causes are infinite, more especially exposure to cold, and, less frequently, to heat; blows, fish-bones fixed in the tonsils, cold draughts, intoxication, repletion, and the ills from respiration."

Paulus Ægineta,[2] in his chapter on Angina or Quinsy, and the complaints allied to it, refers to the disease under the term "paracynanche." "There is redness of the face and neck, and swelling in some cases, and sometimes the mouth is kept constantly open and they cannot swallow drink.....This disease attacks children but rarely, and then only from injuries of the spinal vertebræ occasioned by a fall, which case, being incurable, is not to be meddled with. In the others we must immediately bleed from the arm, and take away not a great quantity at once, but in divided quantities.....Should they not be immediately relieved by it we must open the veins below the tongue, or make incisions in the tongue itself, if it be swelled and protrude out of the mouth."

The learned translator, in his commentary, refers to many other authors, both Greek and Arab, who had described the disease, including Hippocrates, Galen, Cælius Aurelianus, Rhases, &c. Hippocrates, as treatment, recommended, among other things, opening the veins below the tongue.

I think, however, we shall have to admit that these descriptions are rather vague, and that under one term they include several distinct and different diseases, including this suppuration beneath the deep cervical fascia.

It would not serve any useful purpose to trace onwards the accounts of the disease which are to be found scattered through the early medical literature. For, at best, it is by exclusion rather than by actual statement that one gathers that the disease really existed. Thus Dr. Fothergill, in his "Account of the Putrid Sore-throat" (1739–1746), gives an interesting historical sketch of what he believes to have been the same disease as his sore-throat, but he includes, I think, several diseases. There are, for instance, what we now call erysipelatous laryngitis, some cases of which were complicated with secondary cellulitis of the neck. He gives cases also of undoubted diphtheria.[3] There are likewise cases which resemble severe ulcerative stomatitis and noma, scarlatiniform throat and rash—besides the special "sore-throat with ulcers" (which was the subject of his pamphlet), and which he (Dr. Fothergill) regarded as due "to a putrid virus or miasma *sui generis*."

Dr. Thomas Kirkland[4] relates a case, to which he gives the term "angina externa." The patient did not die, having been saved probably by the early median incision which Dr. Kirkland carried out. No explanation of its cause is attempted.

Dr. Wells[5] also relates a "case of extensive gangrene of the cellular membrane between the muscles and skin of the neck and chest." This case occurred in 1809. Patient was a married woman aged twenty-three, suckling an infant of two months. She had been previously well; there does not seem to have been any well-marked cause. The disease appears to have commenced over or near the parotid gland, and thence to have spread towards the clavicle, then over the breast on to the abdomen. "The disease of the skin terminated rather abruptly." The patient died. The case seemed quite new to the author. In describing the partial autopsy, he says: "But had I then thought of it, I should have endeavoured to ascertain by what mechanism the fetid fluid had been prevented from entering the surrounding healthy cellular texture, while it seemed to flow freely through such parts of that texture as were diseased."

Dr. James, of Exeter, in his Jacksonian Prize Essay for the year 1818, also refers to cases of the disease, and adopts Kirkland's name, "angina externa." He says, "It has happened to me to see several." He does not, however, give any cases, but only an imaginary one, tracing the symptoms and course very accurately. His treatment is "a free and deep incision," which he regards as "of the greatest importance."

Dr. Gregory[6] relates a typical case of this disease, to which he gives the name "cynanche cellularis." He says: "It has never occurred to myself to witness anything at all similar to it, either before or since. ..... The disease consisted in an extensive inflammation of the cellular membrane of the neck and anterior mediastinum of a highly malignant character. Its course was rapid, and the symptoms which attended it were of unusual severity." A. J——, aged twenty-five, a housemaid, was taken ill with pain in the back of the neck, resembling rheumatism. This was quickly followed by dysphagia and fever, with swelling, hardness, and some tenderness of the external parts of the throat. The swelling and tenderness extended round the neck on each side, but were chiefly felt and complained of at the junction of the clavicles with the sternum. On inspection of the internal fauces, no enlargement of the

[1] Extant works of Aretæus, Sydenham Society's Edition, p. 250.
[2] Paulus Ægineta, vol. i. Sydenham Society's Edition, page 464.

[3] Dr. Fothergill quotes an extract from the works of Ætius Cletus, which contains the earliest reference to diphtheritic sequelæ with which I am acquainted. "The consequences of this disease were often felt for a long time after it had ceased; an excessive languor and weakness continued for many months, and the voice or deglutition was frequently affected, so as to be perceivable in some almost a year after."
[4] An Inquiry into the Present State of Medical Surgery, vol ii., p. 168. London, 1786.
[5] Transactions of a Society for the Improvement of Medical and Chirurgical Knowledge, vol. iii., p. 360.
[6] The London Medical and Physical Journal, October, 1822.

tonsils or redness or ulceration of palate or pharynx was perceptible; no hoarseness, no dyspnœa. In the course of the next day or two she had difficulty in swallowing, and her breathing also became affected. The disease progressed, and she died on the ninth day. The autopsy revealed "the cellular membrane beneath the skin of the throat and around the trachea, as well as that which connects the pharynx and palate to the surrounding bones, was everywhere in a state of disease, doubtless the result of inflammatory action. In some cases actual *sphacelus* had occurred, in others it was in a state of what might be called *imperfect suppuration*. In one or two points purulent matter was distinctly to be traced. The same disorganised condition of the cellular membrane pervaded the whole extent of the anterior mediastinum, even as low as the point of the ensiform cartilage. While such was the state of the cellular membrane of the throat, the mucous expansions of the palate, pharynx, œsophagus, and trachea, were healthy."

Dr. Graves records a case in his "Clinical Medicine" (vol. ii., p. 521, 2nd ed.):—"Boy, aged twelve, admitted into the hospital labouring under the following symptoms, which he stated were of only three days' standing. He complained of pain in the lower part of the neck, just above the sternum, and extending outwards under both sterno-mastoid muscles, and which was much increased by pressure. There was very little swelling; the space between the two muscles just named, at the lower part of the neck, appeared full; there was no redness or œdema. Just above the sternum there was inflammatory induration, but no soft point was detected. ..... His breathing was hurried and difficult, but *he had no stridor*. He complained of dysphagia. There was no enlargement of the tonsils, or œdema of epiglottis or uvula. He died next morning." At the post-mortem, "On dividing a strong fascia on one side of the (thyroid) gland, a large quantity of extremely fetid pus, of thick consistence and greenish colour, escaped. The gland being divided, an abscess, about the size of a hen's egg, presented itself, lying behind the gland and in front of the trachea. The abscess communicated with two others, one on the right side of the trachea and the other on the left; that on the right extended between the trachea and œsophagus.....These abscesses had no communication either with the trachea or œsophagus."

(To be concluded.)

CASES OF THROMBOSIS, WITH EMBOLIC COMPLICATIONS.

By JAMES MORE, M.D.

As long ago pointed out by Virchow, Kirkes, Tufnell, Trousseau, and other well-known pathologists, thrombosis, with subsequent migratory embolic clots, is a pathological fact susceptible of frequent and almost positive clinical illustration. It is an equally established fact that in every condition of system where, from cachexia or otherwise, the fibrine of the blood is increased, we have the tendency to the formation of coagula and peripheral venous clots. Such coagula, whether primary or secondary, cardiac or peripheral, may reach, through the ordinary blood-currents, the branches of the pulmonary artery, and lead to pneumonic exudation, infarction, or hæmorrhage.

The following cases illustrate in a striking manner these preliminary statements. I may remark they are necessarily incomplete, the diagnosis not having been verified by post-mortem examination; yet from the grave and pronounced nature of the symptoms, and their close apparent affinity to published cases which have been so verified, they have, I think, the merit of great clinical importance.

CASE 1.—Mr. C——, a rather delicate-looking man, forty-five years of age, sent for me one night, complaining of great pain in the lower part of the bowels. I looked upon it as a case of colic, and prescribed accordingly. Next morning the pain was somewhat relieved, but, to my surprise, I found considerable pain on pressure, especially when the hand was pressed deeply into the right groin.

On the third and fourth days of his illnes there was still pain on pressure, with slight tumefaction and swelling in right iliac fossa. The temperature was not over 100°, but he was feeling otherwise better and more comfortable.

On the fifth day, on getting out of bed, Mr. C—— found his right leg in an intense state of cramp, so much so that he could not move it, either in the line of flexion or extension. There was great tenderness all over the limb, and a sensation of fulness and bursting when he attempted to put it to the ground. When fomented the skin looked streaky and marbled, and plainly pointed to venous engorgement. On running my fingers up the course of the large veins, I came upon a large thrombus blocking up the popliteal vein, situated at the peripheral end of the space, and about the size of a large marble. As most of the pain and tenderness had left the groin, the treatment was now chiefly directed so as to relieve as much as possible the unusual strain on the superficial veins, for undoubtedly the large main channel for the return of blood from the leg was blocked up in the popliteal space. He was kept closely in bed, with the limb raised above the pelvic level, and hot fomentations applied two or three times daily. To favour this also, and as his bowels were rather constipated, I ordered him a mild mercurial purge (Plumber's pill), hoping thereby to unload the hæmorrhoidal and other pelvic veins.

On the seventh day of his illness, and two days after the appearance of the knot in popliteal space, I found a bit of it had broken off and been carried up to the top or cardiac end of the space, so that now there were two knots, with a space of two inches between them. They seemed both fixed, and I took care that my patient should not touch or interfere with them in any way. This caution was necessary, as he was anxious to have them rubbed away.

This state of matters lasted for some time, and it was three weeks before the patient could bear the leg to be touched or be put to the ground. When this was attempted, he described the feeling as if the limb suddenly began to fill or swell, and as if it would burst.

About ten days after the appearance of the clots in the popliteal space, I was alarmed one night to find him complaining of pain in the shoulder and upper part of left lung, considerable dyspnœa and bloody sputum. The latter, however, was very slight indeed, and as in the course of the next day or two no dulness or other chest symptoms developed themselves, I was led to hope that the danger of pulmonary embolism was passed. And so it turned out, for he progressed favourably, no other urgent or prominent symptoms appeared, and six weeks after the appearance of the venous clots they seemed getting smaller, and were certainly fixed.

Ten weeks after the initial attack came on the patient was able to walk about the house with moderate comfort, though the venous clots, much reduced, were still there, and the leg still had a tendency to swell, and that in spite of the careful application of a flannel bandage.

CASE 2.—Charles B——, a butler, about thirty years of age, called me in for a typical attack of rheumatic gout in the foot. This, he told me, was the third attack of the same kind he had had, otherwise he looked and felt particularly strong and healthy.

Two days after my first visit I was suddenly called to see him, as he had a severe hæmorrhage from the lungs. This was arrested before I reached the house, but he looked very weak, and complained of pain in his right side. There was no dulness on percussion, but moist râles all over the base of right lung. The pulse was the best example I ever met with of a high blood-pressure pulse. It was a slow, full, round pulse, not easily compressible, and easily traced far up the forearm. When compressing the brachial it (the pulse) disappeared, only to return with increased volume when the pressure was removed. I prescribed an ergot mixture, a plentiful supply of ice, and, as his bowels were obstinate, a Plumber's pill at night and castor oil in the morning.

On the fourth day of his illness a second hæmorrhage came on to a considerable extent, and now, on examination, I found extensive dulness all over base of right lung. I should add that before I had seen him at all he had applied a "black blister" over his gouty ankle, and when the swelling and irritation from this subsided, the gout in the foot had disappeared.

On the fifth day of his attack intense pain of a crampy character came on in the calf of the gouty leg, so that he could not move or stretch it out. On examination I found great tenderness along the course of the external saphenous

vein, which also felt knotty, and looked somewhat red, just above the origin of the tendo Achillis.

On the sixth day he had just a show of blood in his expectoration, and from this date he began to show signs of improvement. The dulness in lung gradually cleared up, and but for the pain and weakness of right leg he felt fairly well, when he left this neighbourhood for Kent, which he was able and obliged to do about five weeks from the commencement of his illness.

CASE 3.—George J——, a tall, broad-chested Scotch footman, consulted me for symptoms which were anything but definite—namely, weakness, languor, anorexia, and slight cough. On account of the latter I examined his chest, but found nothing to lead me to suspect pulmonary mischief. When he had been under treatment about a week he had a smart hæmorrhage from the lungs, and on examining his chest a second time, I found well-marked consolidation of the upper part of the left lung. The fiæmorrhage lasted during one day, and there was slight dyspnœa, but no intensification of the other symptoms. To his general symptoms of malaise were added in the course of the next few days increased cough, night-sweats, a rise in temperature, and I must say his case looked like one of incipient phthisis. To favour this idea, he had well-marked filbert-shaped nails, but he maintained that back even to the third generation there was no history of phthisis in his family.

Ten days after the hæmoptysis, pain of an intense crampy nature appeared in the calf of his left leg; the limb felt painful to the touch, and like to burst when put to the ground. In the lower part of the calf of the leg, the saphenous vein was well-defined, painful when touched, marked along its course by a pinkish blush, and filled by a chain of embolic clots.

Under appropriate treatment this knotted and phlebitic state of the vein disappeared in the course of ten days, though the circulation of the leg remained weak, and had to be supported by careful bandaging for some time.

Six weeks after the hæmorrhage the general symptoms remaining were those apparently of phthisis—viz., debility, cough, loss of flesh, dulness in upper lobe of left lung, shortness of breath when walking up stairs, with a pulse about 90 and a mean temperature of 100°. Phthisis it may eventually turn out to be, but the initial symptoms it must be confessed show considerable divergence from the usual course of this disease, and I think I am justified in recording it in the same category as the others—viz., peripheral thrombosis with embolism, the embolic complication in this case, as in the second, being hæmorrhagic infarction of the lung.

In the origin and grouping of the symptoms we have the recognised elements of this pathological state, because there were (1) undoubted evidence of thrombosis and embolism, the latter accompanied by its characteristic dyspnœa; (2) the capillary hæmorrhage, a hæmoptysis characteristic as to onset, quantity, and colour; (3) hæmorrhagic transudation into upper lobe of lung, as evidenced by the dulness on percussion; (4) and this ending in a low form of pneumonia, with a mean temperature of not more than 100°.

Gerhardt[1] says "the diagnosis of hæmorrhagic infarction is easy to make in most cases, especially in cardiac cases, and in cases of thrombosis of the crural veins or those of the calf"; and, further, that the diagnosis may be "determined if there obviously exist embolic material and an embolic attack, and when the diagnosis is confirmed by absence of fever, dulness in the lower lobe, lasting for some weeks, and hæmoptysis."

Feltz has also pointed out that hæmorrhagic infarction of the lung always originates in hæmorrhage, resulting from rupture of the capillaries. And, again, according to Gerhardt, "the earliest and truest of the symptoms of the hæmorrhagic infarction is spitting of blood"; and this hæmoptysis may be pure blood, as noticed by Laennec, Dettrich, and others.

Hæmorrhagic infarction is not necessarily pneumonic, but, according to Rindfleisch,[2] it "is merely a preliminary to the actual inflammation, and is the first result of the embolism, the inflammation (embolic pneumonia) being as something superadded or secondary." It might be objected that in this case the embolic symptoms proper did not appear till ten days after the hæmoptysis and the lung deposit, whereas it ought to have taken precedence in point of time. But as embolism may be so urgent and pronounced as to cause sudden death itself, it may nevertheless be so masked and of such a degree as to "occur almost or altogether without symptoms" (Gerhardt). Having the embolic material there, the sudden lung deposit appearing with dyspnœa after the hæmoptysis, coupled with the important point of a non-pneumonic temperature, we have, I think, a right to conclude that the first embolic act leading to the infarction passed unnoticed. To throw a final stone on the cairn of evidence, I would quote again from Gerhardt, who says: "It is indeed frequently the supervention of infarction of the lungs which first gives a certain basis for the diagnosis of thrombosis."

In my first case, that of Mr. C——, the chain of distinctive symptoms is more complete, for (1) there was the congestive attack over or near the external iliac vein. And here I may be allowed to quote Trousseau[3] on the probable results of such a complication: "It is a remarkable fact that frequently, as soon as there is an obstacle to the venous circulation, fibrine is precipitated, so to speak, into the valvular pouches, giving rise to the knots in the course of the veins." There were (2) the sudden cramp and other decided symptoms of venous obstruction in the leg of the same side; (3) the presence of the thrombus and embolus in the popliteal space; (4) the attack of dyspnœa and subsequent bloody sputum; (5) the resulting œdema of the limb.

In the second case, that of the gouty butler, the symptoms of embolic infarction are still more pronounced; for—(1) In the presence of gout and the fact of the blister over or near the origin of saphenous vein, we have the dyscrasia, "the pathological aptitude," or tendency to this complication; (2) the decided fact of the embolic act, as seen in the dyspnœa, inability to lie down, sudden crampy pain in calf of leg, embolic knots in saphenous vein; (3) hæmoptysis of pure blood, followed by dulness in lower lobe of left lung, a slowly developed lobar consolidation, with comparatively low, at least non-pneumonic, temperature.

It is worthy of remark that in the last two cases the hæmoptysis appeared to be the initial symptom, but the pain in calf and appearance of emboli in the limb must, of course, be held to represent a *repetition* of the embolic act, which subsequently led to the hæmorrhagic infarct. And, of course, an embolus cast adrift from a thrombus, before it could reach the pulmonary artery, must be supposed to travel straight to its destination, without causing obstructive symptoms by the way. Indeed, in all the three cases, there must have been repeated embolic acts, causing hæmoptysis and lung deposit on the one hand, or, being arrested by the way, causing obstructive symptoms in the veins in the other.

Clinically speaking, these cases in their more salient symptoms form a synthesis undoubtedly leading up to embolism, and a rough analysis of those same symptoms, still more decidedly, points to this vascular obstruction as being their true and only rational pathology.

Nothing, I think, need be added as to the great and urgent importance of an early recognition of such cases; for anyone must see that if a phthisis or a pneumonia owes its origin to embolism, the danger of a sudden and deplorable *contretemps* is increased tenfold.

Rothwell, Northamptonshire.

[1] German Clinical Lectures, page 277.
[2] Pathological Histology, vol. ii., p. 67.

FOREIGN BODY IN THE RIGHT BRONCHUS; EXPULSION ON THE ONE HUNDRED AND SECOND DAY.

BY H. B. YOUNG, A.M., M.D.

THE report of the following case was suggested by the article on a similar subject by W. Beattie Smith, L.R.C.P.E., in THE LANCET of June 28th, 1879. It occurred in this place some fifteen years since in the practice of my father, Dr. John A. Young (now deceased), and has never been published.

On Sunday evening, April 24th, 1864, W. C——, a bright boy aged five years, while playing with an oval glass-bead three-quarters of an inch in length and one-quarter in

[3] Clinical Medicine, vol. v., p. 300.

idth, perforated longitudinally, put it in his mouth, and, in attempting to bite it, it suddenly slipped from between his teeth and found its way into the *right* bronchus. The usual means for dislodging, inversion, shaking, &c., were immediately resorted to, and during the course of the evening several times repeated, but all without effect. As the dyspnœa was not great, however, and the child in no particular distress, it was resolved, as in the case reported by Mr. Beattie Smith, to temporise. If an operation should prove to be necessary, the conditions would certainly be none the worse for a little rest.

The following morning, after another unsuccessful repetition of the inversion process, it was agreed, in consultation with other physicians present, that tracheotomy, with a view to extraction, was the most promising course, and it was accordingly done. But with all the forceps to be had, and a slender probe hooked at the extremity and introduced after the forceps, all attempts for the removal of the obstacle were equally unsuccessful. That the bead was far from stationary was clearly demonstrated. A cough being induced, it could be heard to come up into the trachea with a bound, to sink back again on deep inspiration when the cough ceased. The hope was then entertained that another visit might find a different situation of affairs—the bead possibly lodged within easy reach of the forceps. The tube was therefore inserted, and the wound dressed.

Three or four visits were made daily after this, but nothing of importance occurred until the fourth day (Friday), when at 11 o'clock A.M. there was a sudden, and although lasting only a few minutes, a serious hæmorrhage. The tracheal wound was at once examined, but the trouble was evidently at some point below, as this was found in excellent condition. At 11 o'clock P.M of the same day a second and much more serious hæmorrhage followed; indeed so serious was it, that after the air-passages were once cleared, and the child laid down, it was thought he would immediately die, so great was the exhaustion from loss of blood. He rallied, however, after a time; and there being no return of the hæmorrhage by morning, he was comparatively comfortable, though very weak. That evening (Saturday), it being deemed unsafe to further irritate by any attempts at extraction, and the child having fretted considerably over his inability to speak aloud, the tube was removed, and the tracheal wound closed up. Absolute quiet for some days to come, and a careful attention to nourishment, being the pressing necessities, all other proceedings were left for time and events to determine. With the closure of the tracheal wound came the whistling respiration mentioned in Mr. Beattie Smith's case, which in like manner was attributed to the passage of air through the opening in the bead. This was present so long as the bead remained in the bronchus.

From this time on there was little active interference with the case. The recovery from the effects of the hæmorrhages was rapid, and with the exception of some dyspnœa after lively play, and an unequal chest expansion, the left side apparently doing all the work, the child seemed fairly well.

On Wednesday evening, August 3rd following, 102 days after the accident, a sister of the boy came running to say that the bead had been expelled. A call at the house at once showed this to be true. It appeared from the story of the boy himself, as well as that of the older ones with him, that he had had a sudden fit of anger in his play, and had thrown himself headforemost over the end of a reclining lounge which stood near; that in this position, with his feet up and his head down in giving vent to a terrific cry, the bead shot from his mouth with such velocity as to carry it some four or five feet away across the floor. It was not at first known to be the bead, but on picking up the object which in flying out of his mouth had so suddenly stopped the boy's crying, and wiping off the mucus which covered it, it was found to be that troublesome article. More than this was discovered. At one end of the bead, instead of the usual smooth surface surrounding the opening, was an uneven facet, the result of a chipping. At one side of this facet was a moderately sharp projection, doubtless the cause of the hæmorrhages.

Of the subsequent history of the case there is none. The child had no further attention, thrived, and grew to be what I saw him yesterday, a strong, hearty, and well-developed young man.

In conclusion, I have only to add my regrets that I am unable to give a more detailed account of this very interesting case. Among my father's papers I find but little about it, and the memory of those connected with it does not reach with accuracy to such matters as temperature, chest-sounds, amount of blood lost (which must have been considerable) at the two hæmorrhages, &c., which it would be desirable to know. That the case might prove interesting with an enumeration only of the most important occurrences, and instructing from the sufferance it shows in a young and healthy lung, which, after three months of obstruction, entirely regains its efficiency, is my apology for presenting it in this imperfect manner.

Monmouth, Illinois, U.S.A.

SOME EFFECTS OF POISONING BY ALCOHOL.

BY W. T. PARKER DOUGLAS, B.A., M.B.

THE following data of a case which has recently terminated fatally may be of interest to others, as it has been to myself, inasmuch as it exhibits some uncommon occurrences produced by the persistent imbibition of ardent spirit.

The subject of these remarks was the wife of a retired farmer and landed proprietor, the mother of five children, and thirty-six years of age. For seven years she had been addicted to intemperance (which appears to have been hereditary). On two or more occasions she had delirium tremens, and but rarely, and only for short intervals, was either temperate or abstained altogether. For a period of eight weeks prior to her decease she was sober only nine or ten days, and the quantity per diem consumed varied to a maximum of four pints of raw spirit (either brandy or whisky).

The first effect of drinking with her was violent heart-action, followed by almost imperceptible pulsation. Then stupor, from which she awoke to a sense of chilliness and shivering, with nausea, but no vomiting, and never complained of headache. During the last eight days of life she was helpless to do anything for herself, and took but little stimulant, for which she had then a loathing. Five days prior to death the skin was sallow, face bloated, tongue dry, furred, and brown; sordes on teeth and lips; nasal mucous membrane dry, and bleeding occasionally; intense gastric pain, with violent retching and vomiting of "coffee-grounds" matter; abdominal distension and tympanites; liver dulness diminished; the excretion from the bowels principally of digested blood; urine scanty, and deeply coloured with bile; in addition to the hæmorrhage from the nose, stomach, and bowels, there was also bleeding from the uterus and from the left ear. Two days later superficial gangrene commenced in spots on the pinna of the left ear, and on the cheek an inch above the left angle of the mouth. The former was localised, but the latter extended and involved first the upper lip, and, spreading upwards, included the skin of the nose and adjoining portions of both cheeks to the margin of the lower eyelid on the right side, and across the bridge of the nose, affecting both lids of the left eye, which was closed, and the lids glued together by secretion; thus forming almost a circle which would correspond pretty accurately to the surface covered and included by a glass tumbler, as in the act of draining the last dregs of its contents.

The localisation of the gangrene was, at least, peculiar, but of the cause of its determination to that particular portion of skin I am not prepared to offer an opinion, though I cannot but think that, in drinking, the alcoholic vapour may have been an element in its causation. The patient made no complaint of pain in the face; in fact, for forty-eight hours prior to death, she was perfectly conscious and free from pain, and only distressed with weariness. Diarrhœa at last set in, and the pulse, which for three days beat at the rate of 140 to 150 in the minute, gradually grew fainter. I may add that nowhere else but in the parts indicated was there a spot of gangrene.

Newbury.

A Mirror OF HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum, tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Proœmium.

CENTRAL LONDON SICK ASYLUM.

STRANGULATED UMBILICAL RUPTURE; HERNIOTOMY; RECOVERY.

(Under the care of Dr. LEDIARD.)

MATILDA S——, aged fifty-six, a charwoman, was admitted on April 5th, 1879, suffering from acute symptoms of strangulation in an umbilical hernia of eight years' standing. The patient was a short and fat woman of fairly healthy aspect. She stated that she had never been pregnant, and that eight years before, when lifting a washing-tub, she first ruptured herself. The swelling was at first not larger than her thumb; nothing was done for it, and she never wore a truss. This rupture remained without troubling her until eight days before admission, when, while turning the mangle, she strained herself, and the rupture became suddenly larger, and was accompanied by pain. Vomiting set in five days after the accident, and up to three days before admission she had taken no food for a week, and the bowels had not been open for six days.

On admission, a moderate-sized umbilical hernia was found on the left of the navel, about the size of an orange, of somewhat crescentic shape. It seemed to be partly firm and unyielding and partly elastic, as if it contained intestine and omentum. The abdomen was somewhat distended, but there was no evidence of peritonitis. The woman was at once placed in a hot bath, and reduction was attempted for a quarter of an hour whilst she was in the bath, but without success. She was then carried to bed, some calomel and opium was given, and an ice-bag was applied to the hernia; the lower bowel was also cleared out with an enema.

The woman passed a fair night, but had pain in the abdomen, and vomiting continued; the matter brought up was, however, not stercoraceous; the belly was now swollen and tympanitic. The hernia was again manipulated, but unsuccessfully. The tongue was thickly coated, but not dry, and the pulse was rapid, though not of unsatisfactory nature.

At 3.30 P.M. (on the 7th) chloroform was given, and taxis was again tried, but this failing, herniotomy was proceeded with. A small incision was made over the tumour and somewhat to the left of the umbilicus, and the sac was reached at once, the coverings being, as usually described, very thin indeed. The hernia appeared to be divided in two parts by a septum, and it was necessary to open the sac in order to proceed further. When this was done, a large piece of omentum was exposed, partly old and partly of recent protrusion, and a coil of small intestine about three inches long. The gut was congested, but not inflamed; the opening into the abdomen was about the size of the end of the little finger. The bowel was returned by drawing the omentum forwards and pushing the gut backwards, without enlarging the ring. All efforts to restore the recently-protruded portion failed, and accordingly a large piece was cut off the base, having been previously ligatured. The incision was then brought together, and the pedicle of the omentum plugging the ring was transfixed by one suture and enclosed in the wound. The wound was dressed with dry lint. During the operation several ounces of fluid escaped from the abdominal cavity. It is not easy to account for this, as the kidneys, heart, and liver were apparently healthy, unless the effused serum was due to some congestion of the bowels.

The vomiting did not return, and the bowels acted naturally on the ninth day, and, although the general condition was in all respects satisfactory, the wound soon assumed an unhealthy character. There was little or no primary union, the sac sloughed out, and the remains of the omentum had to be cut away, bit by bit, till at length a rather large and deep granulating surface remained between the skin and muscles where the old hernia had existed, the wound healing entirely by granulation.

On the 28th, or three weeks after operation, the patient was allowed to get up, there being no trace of any projection at or near the navel, and the hernia being radically cured.

The temperature rose to 102° within the first twenty-four hours of the operation, but fell to the normal standard on the fifth day. The excised omentum measured 4½ inches long by 3½ inches wide at the place of section. The distal portion which had caused the chronic hernia was sausage-shaped; the weight of the entire mass was rather under an ounce.

Mr. Hey's remarks on the treatment of omentum[1] are of much practical value, and are well worth perusal. He states that he once removed five or six ounces of this tissue without bad result. In turning over the pages of THE LANCET for the last three years, amongst the numerous cases recorded of hernias operated upon, there seems to be but one case of strangulated umbilical hernia for which an operation was performed,[2] and this one occurred in Mr. Sheaf's practice. In that instance the sac was not opened, and the case did well. Most authorities agree in the statement that recovery is rare when the sac has been opened.

NORTHERN HOSPITAL, LIVERPOOL.

CASE OF POPLITEAL ANEURISM RECURRING AFTER APPARENT CURE BY MEANS OF ESMARCH'S BANDAGE; COMPRESSION OF MAIN VESSEL BY TOURNIQUET AND WEIGHT; CURE; REMARKS.

(Under the care of Mr. CHAUNCY PUZEY.)

THE following report, prepared principally from the notes taken at the time by Dr. James Allan, late house-surgeon to the hospital, should be read in conjunction with Mr. Rushton Parker's article on Popliteal Aneurism published in our columns last week. Mr. Parker refers to this case on page 536.

Patrick L——, a labourer, aged about thirty-six, was under treatment in the hospital for popliteal aneurism in the autumn of 1877, and was discharged, having been apparently cured by means of Esmarch's bandage. (The case is reported in "The Mirror" of THE LANCET of January 19th, 1878.) He was readmitted on the 30th December, 1878, and gave the following account of himself. He was troubled with some stiffness and numbness of the affected knee and leg at the time of leaving the hospital in 1877, but he took little notice of it, although it prevented him from doing any but light work; the limb as far up as the knee always swelling during the day, and being relieved by the night's rest. The numbness was so pronounced that the man said he could put a knife into it without feeling pain. At the same time he could feel slight pulsation at the back of the knee, and seven or eight months later this was more marked. Fourteen days before his readmission the pain and "beating" became suddenly worse without any apparent cause, and he could hold out no longer.

On admission, he appeared to be in fair health, but had the aspect of one suffering great pain. The tumour occupied the usual site of popliteal aneurism, projecting considerably at the back of the limb, and bulging somewhat on each side; it felt firm, as if the sac-wall was tolerably thick, but the pulsation was very marked, raising the knee, and shaking the whole limb when the leg lay flat on the bed. The measurement of the thigh, taken over the most prominent part of the tumour, was 15 in.; that of the corresponding part of the opposite limb, 13½ in. Flexion of the knee controlled the pulsation to a considerable extent, but was hardly tolerated by the patient on account of the excessive pain caused by the procedure. He also strongly protested against any further attempt at treatment by elastic bandage. It was therefore decided to treat the case by compression of the main vessel, after allowing the patient a few days for rest and preliminary general treatment. It should be mentioned that examination showed that the femoral artery could be traced down to, and also along, Hunter's canal, as

[1] Practical Observations in Surgery, third edition, 1814.
[2] THE LANCET, Nov. 2nd, 1878, p. 618.

far as the aneurism, so that the vessel was evidently completely pervious throughout its entire extent.

On Jan. 2nd Carte's compressor (for the groin) was applied for about two hours, next day for four hours, and then, after a short interval, for two hours by alternation of Carte's compressor with a conical lead weight of four pounds, according to Bellingham's method, Carte's compressor being applied to the groin just above Poupart's ligament, the conical weight to the highest portion of the superficial femoral artery. The groin had of course been previously shaved, and the parts pressed upon were kept well covered with oxide of zinc. As the weight did not completely stop pulsation, the patient or an attendant kept a hand gently resting upon the top of it, so as to control the circulation completely. One-third of a grain of morphia injected subcutaneously twice a day was found sufficient to keep the patient tolerably comfortable. He was allowed bread and meat, but as little fluid as possible, ice being given to check thirst.

On the 4th pressure was kept up for about seven hours. Rings of metal were added to the weight so as to increase the compressing force, and, as the end of the cone hurt the patient's thigh, a cap or thimble of soft cork was fitted over the end of the weight. The patient suffered from nausea and headache. The bowels were moved by an enema. The subcutaneous injections of morphia were continued, with the addition of one-sixtieth of a grain of sulphate of atropia.

On the 5th pressure was borne much better, and was kept up for eight hours instrumentally and one hour digitally. In the morning there seemed some slight lessening of pulsation in the tumour. Next morning (6th), before pressure was begun, the patient felt the knee easier, and the pulsation was less. Pressure was kept up for eleven hours, from 10 A.M. to 9 P.M. At 5 P.M. Dr. Allan noticed marked consolidation, and the 4 lb. weight was quite sufficient to check all pulsation; this weight was therefore kept on until 9 P.M., and then there was no pulsation in the tumour nor in Hunter's canal, but three large branches could be felt pulsating superficially, one at each side of the knee, and one over the posterior surface of the aneurism.

On the 7th the aneurism felt consolidated; there was no pulsation; the weight (4 lb.) was continued. The patient was quite comfortable, the foot being wrapped in cotton-wool.

On the 12th all pressure was stopped. The measurement round the aneurism was half an inch less than on admission. The foot was warm and moist; it was kept wrapped in cotton-wool, with oil-silk covering.

From this time there was nothing worthy of special note, except that the patient continued to complain of that stiffness and numbness of the foot which had, according to his statement, been present ever since he was under treatment in 1877. Various local applications were tried—belladonna, aconite, amyl-colloid, blisters,—without any good result. The symptoms were probably not due to nerve-mischief, and, as these sensations were generally relieved by raising the leg, although there was no apparent fulness or swelling of the limb, light bandaging of the leg with Martin's bandage was tried; and very soon an improvement was manifest, and the man left the hospital quite well on the 6th of June. For more than a month before his discharge it was impossible to feel the situation of the aneurism, so completely had all traces of it disappeared.

Remarks by Mr. PUZEY.—Several cases of aneurism have lately been reported in THE LANCET, and among these have appeared some in which the use of Esmarch's bandage had failed to effect any benefit, and some, on the other hand, in which a successful issue had *apparently* resulted from the use of this bandage in combination with other forms of pressure. And now that this method of applying pressure appears likely to be adopted as a recognised mode of treating aneurism occurring in the extremities, it seems desirable that we should be furnished with some precise information as to the *later history* of the cases treated in this fashion. Only a few weeks ago I observed the report of a case thus treated in which the patient was stated to have been discharged "cured" a fortnight after admission. The question arises whether any case of aneurism can be declared to be "cured" after only two or three weeks' observation; and, further, whether this remark may not be found to apply more especially to cases treated by this method, which aims at filling the sac with a large quantity of rapidly formed and therefore loose soft clot, which may never become firm and is liable to break up on the slightest movement. Then, unless the artery has been occluded, as soon as the patient begins to move about, blood may find its way into the sac, which rapidly refills, and the work has to be done over again. *Primâ facie*, it appears to me that there are several possible objections to this method of treatment; especially, as now generally applied, with the idea of locking up a large quantity of blood in the aneurismal sac. Is there not some risk of rupturing the sac? Is it not at least probable that the sac is overdistended, weakened, and, perhaps, enlarged? Does not the elastic compression paralyse for a time every artery in the limb, and thus, perhaps while assisting in the speedy establishment of collateral circulation, do harm by allowing too large a quantity of blood to find its way into the diseased vessel below the aneurism, thus neutralising the effect of the digital or tourniquet pressure which it appears necessary to keep up on the main vessel after removing the Esmarch's bandage? The proceeding is always very painful at the time, and frequently followed by long-continued pain and stiffness of the limb. I think that it will be generally admitted that the long-continued constriction with the Esmarch's tube or cord is attended even with some risk to the limb, inasmuch as it has been followed by more or less serious paralysis, owing to damage inflicted upon large nerve-trunks, and that, therefore, only the elastic bandage is admissible; and if this bandage is kept on for an hour or more, a large quantity of blood which should be circulating in the limb thus being forced into the general circulation and over-distending perhaps diseased vessels, does not this involve serious risk, as pointed out by Dr. Mahomed, especially if the patient is struggling in the early stage of the administration of an anæsthetic? No doubt if this mode of treatment is shown to be tolerably certain to produce a *permanent* cure, it is worth while to run some risk; but on this point it seems to me that information is wanted, and is now to be obtained, if those gentlemen who have published successful cases will make known the present condition of the patients referred to, and state whether there has been at any time a return of pulsation in the diseased vessel. The case that I have recorded tends to show, as does that recorded by Mr. Parker, that something more than consolidation of the contents of an aneurism is necessary for its cure, and that only when the artery itself, from which the aneurism springs, is occluded can a certain cure be relied upon.

MONTGOMERYSHIRE INFIRMARY.

ABSCESS OF KIDNEY; HYPERCINESIS OF BLADDER; DEATH.

(Under the care of Dr. PRATT.)

M. E——, aged twenty-seven, married, mother of three children, was admitted into the infirmary on March 31st, 1879. She was a thin, delicate-looking woman, suffering evidently from chronic bad health. The account she gave of herself was that she had been ailing more or less for six months. About three months before admission she had been confined of her third child, and although the labour was natural, she had suffered much ever after. Her only complaint was incontinence of urine, with great bearing-down. The bladder did not contain a teaspoonful of urine before she was compelled to void it, and the act was accompanied with much forcing and great scalding. Every five minutes the expulsion was repeated, and the moanings of the patient were pitiful to hear. She obtained no peace day or night, unless when under the influence of "a draught."

On examination the orifice of the urethra was quite pale, as was also the vulva. All excoriations had been avoided by frequent washings. On introducing the finger into the vagina, the uterus was found prolapsed, but structurally quite healthy. The bladder was empty, and during the short examination a severe spasm occurred, which drove it almost out of the vagina. The introduction of a catheter caused great pain as it passed along the urethra, and when in the bladder it was violently seized by that viscus, and a tonic spasm held it immovably, causing much suffering to the patient. She had no pain when pressure was applied over the hypogastric region or over any other part of the abdomen. The thoracic organs appeared healthy. It was difficult to obtain any of the urine, but by great care on the part of the nurse, enough was collected to fill a champagne-glass. It was very pale, neutral, specific gravity 1010, and yielded on standing a white precipitate, which under the

microscope contained no casts, but an abundance of cells, to all appearance pus-cells. When tried with heat and nitric acid it yielded albumen to one-half its volume. Disease of kidney was diagnosed, and the worst prognosis given. Inasmuch, however, as the patient's previous medical attendant had suspected stone in the bladder and had actually sounded her three times without finding one, and as the disease of the kidneys did not seem to account for the constant and terrible vesical spasm, the patient was put under chloroform about three days after admission. The urethra was rapidly dilated with a two-bladed dilator, the index finger was introduced, and the whole of the bladder carefully explored with negative results. No stone, no ulceration, absolutely nothing was found in the bladder. It was noticed, however, that not till the narcotism had been pushed to the utmost did the vesical spasm abate. By this exploration the former diagnosis was confirmed. The kidney disease was evidently the cause of all the symptoms. The patient was now put upon a milk diet, with a mixture of buchu, henbane, and nitric acid, to which was added, if necessary, an occasional opiate draught.

After the actual pain of the forcible dilatation had passed away, the vesical spasm seemed certainly relieved, the woman could retain her urine for a short time, and void it with less suffering. The albumen, however, did not diminish, and the symptoms of general weakness increased. About the end of the second week the patient complained principally of a tightness about the chest and a nasty taste in the mouth, which symptoms were purely subjective, and thought to be caused by the presence of urea in the blood.

On April 17th she complained still more of this tightness. The heart's action now became very weak, in spite of wine administered in some quantity, and towards midnight it ceased rather suddenly, and she died.

A necropsy, limited to the abdomen, was made twenty-four hours after death. On opening the abdominal cavity, extensive peritoneal adhesions were found almost everywhere, matting all the contents together. The bladder was empty and quite healthy. The right kidney was double the normal size, but otherwise healthy. The left kidney, very little above the ordinary dimensions, was one large pouch of pus, which had not yet emptied itself. No trace of kidney structure was left, and although the capsule was thickened and adherent, the kidney abscess must shortly have burst, the wall of the pouch in some parts was so thin.

This case is interesting from all the symptoms having been referred to the bladder, which, healthy in itself, was in a state of constant and cruel spasm, whilst the real disease was abscess of the kidney.

Medical Societies.

CLINICAL SOCIETY OF LONDON.

Leprosy, with Enlarged Glands.—Myxœdema.—Excision of Rib in Empyema.

THE first ordinary meeting of this Society after the recess was held on the 10th inst., the President, Dr. Greenhow, F.R.S., in the chair. An exhaustive report on a case of leprosy, with enlarged glands, was brought up from a committee, and read by Dr. Powell. This was followed by some interesting contributions to the subject of myxœdema by Drs. Duckworth and Ord, and the proceedings closed with a case read by Dr. Taylor, in which an empyema had been treated by the excision of portions of ribs by Mr. Howse. Time, unfortunately, did not permit of the full discussion of the value of this measure. Two rare cases of skin disease were shown by Dr. Crocker, the one being a congenital sebaceous affection (syphilitic (?) in an infant, the other a tubercular eruption on the scrotum of a boy.

Dr. DOUGLAS POWELL read the report of a committee appointed to investigate a case of Leprosy with Enlarged Glands. The case was a remarkable one in many ways. Its earlier history is to be found in the Pathological Transactions, vol. xxix., p. 338, contributed by Surgeon-Major Porter, of Netley, the patient being a corporal in the army, invalided home from India. He had then considerable glandular enlargement in the neck, axilla, and groins. Dr. Powell recapitulated the history of the case, pointing out that, while at Netley, the leprous condition of skin became slowly developed, the face gradually assuming the characteristic leonine appearance. He was treated with phosphorus, and, a few months after leaving Netley, was admitted in January, 1879, into the Middlesex Hospital under Dr. Powell's care. Although only twenty-four years of age, he then had the aspect of a man of forty-five. His face was large and furrowed, scalp thick, eyebrows absent, auricles thick. There were some enlarged glands in the submaxillary, axillary, and inguinal regions, but to a far less degree than when first admitted at Netley. There was no œdema of legs. There was an ulcer on dorsum of right foot. No anæsthesia. No albuminuria. The blood was examined for filariæ without result. He was shortly after brought to the Society, and a committee, consisting of Drs. Cayley, Duckworth, R. Liveing, and Powell, nominated to report on the case. Slight thickening of the right ulnar nerve was detected at the bend of the elbow. Gurjun oil was prescribed. He improved, and resumed active life, helping in ward duties; but on March 5th he complained of headache, and the skin of the right arm became the seat of erythematous inflammation. This erythema gradually spread over the body, neck, face, and scalp; and at the same time indications of lobular pneumonia developed. On the 20th the spleen was noticed to be greatly enlarged. On the 22nd blood appeared in the urine; he sank into a typhoid state, and died on the 30th. At the post-mortem examination the skin, even where during life it had been thickest, was now tense, shining, and comparatively thin. The glands were curiously tough and fibrous, and there was lobular hepatisation in both lungs. Distinct changes, due to inflammatory cell-formation, were found in the ulnar nerve, producing thickening of the peri- and endo-neurium, and shrinking of the axis-cylinders. There was thickening of the connective tissue in the skin, and in the glands notable fibrous overgrowth, especially around the vessels. The committee report that the case presented the clinical features of the tubercular variety of elephantiasis Græcorum, unattended with altered sensibility, and associated with great enlargement of lymphatic glands—a feature not unusual in leprosy (Hebra). The amendment in his general condition and the reduction in the size of the glands under treatment by phosphorus, were remarkable; but it did not affect the leprous features of the case. The termination of the case was also interesting—a spreading erythema, remarkable for its acute onset and involvement of the whole body. The anatomical conditions accorded with those met with in leprosy in its early stage. A notable reduction took place in the richness of the blood in red corpuscles. The condition of skin found after death was owing to the recent inflammatory attack. The condition of the glands was that of atrophy and fibroid induration. How far phosphorus was operative in producing this is uncertain.—Dr. T. C. FOX mentioned that glandular enlargement in leprosy had been described by Carter in India, and Hansen in Norway, the latter stating that it is met with in two-thirds of the cases. The same author describes peculiar tailed and degenerate cells in the affected glands.—Dr. POWELL said that no such cells had been noticed, but the specimens should be again carefully scrutinised. The case, so far as its morbid anatomy goes, showed the features of leprosy in an early stage.

Dr. DYCE DUCKWORTH read notes of a case of Myxœdema, the patient, a female thirty-four years of age, being exhibited. She had been married ten years, and came under his care a year ago with the statement that she had for two years suffered from weakness, which began with swelling of eyelids and right side of face. Her mental condition, too, had changed; she had become abstracted and somnolent. The skin of the face had a peculiar waxy, sallow appearance; the eyelids and cheeks were puffy, and the dorsum of each hand also puffed. The voice was thick and snuffling. She complained of tingling of the hands; there was no anæsthesia. There was some general scleroderma. The urine was of specific gravity 1010, and free from albumen. Heart natural; appetite good. The urine was examined every time she came, but never contained albumen. She gained in weight, but began to complain of feeling cold. The idea of Bright's disease not being tenable, on her third visit Dr. Duckworth concluded the case to be one of the class to which Dr. Ord had recently drawn attention under the head of

"Myxœdema," and then he recalled two or three similar instances in women which he had formerly thought were simply anæmic. The father of this patient was paraplegic a year before his death. One of her children was rickety; the rest healthy. She began to stagger in walking, and to be more irritable in manner. The thyroid could not be felt. At the present time the face is more puffy and waxy-looking than at first; speech is slower, and movements less active. The affection is evidently progressing. Dr. Duckworth remarked that hitherto no cases of this disease had been recorded save by London physicians; that it had never been observed in males, but only in adult females. It would be interesting to trace the history of the children of these patients. The most obvious symptoms were those of mechanical interference with nerve-function by the progressive and universal mucoid degeneration of the connective tissue. Taken collectively, the symptoms pointed to a general cachexia.

Dr. ORD also read a paper on the same subject. He stated that two years ago he proposed (in a paper published in the Medical and Chirurgical Transactions, vol. lxi., p. 57) to apply the term "myxœdema" to the condition described by Sir William Gull as a "cretinoid affection occurring in middle-aged women." Since that time he had had six cases under observation at St. Thomas's Hospital; one of these terminated fatally, and he read the notes of it in full, summarising the features of the other cases. The fatal case was that of a married woman fifty-two years old, who had five children. She was admitted on Feb. 4th, 1879. Her mother had died dropsical. She herself had led an active, hard-working life, and had enjoyed good health, but after the birth of each child she had some puffiness of face, and since her last confinement she had been getting weaker. Her gait became staggering, her memory became defective, her speech slow, and she always felt chilly. The face was puffy, especially about the eyelids, the alæ nasi thick, and there was a deep pink flush on the cheeks. The expression was dull and sad; the skin appeared swollen and translucent; the hands were "spade-like"; the abdomen was large, its walls lax; the back was bowed. The thyroid could not be felt. There was some fluid œdema in the legs and feet. She moved slowly on trying to walk, and tended to fall, but there was no limb-paralysis. Speech began by making an effort at swallowing, and the words were interrupted by sudden closing of the lips. She was lethargic. The special senses were not affected; touch was accurate. There was some bronchitis. The pulse was tense. Urine, 1015, contained a trace of albumen; no sugar. The temperature was very low—viz., 90·8° in right axilla, and 91° in left. A sudden mental shock a few days after admission was followed by deeper lethargy and delirium, and she died on the fourteenth day of her stay in hospital. During this time the temperature varied from 90° to 92°, never exceeding 94°, and before death falling to 87° and 77° F. At the post-mortem examination there was effusion in the serous sacs. Heart flabby and dilated. The connective tissue was everywhere increased in quantity and mucoid in character, its fibrils distinct, their nuclei large and abundant. The arterial coats were thickened, and the calibre of the vessels diminished. There was increase also in the stroma of the liver and kidneys, as well as in the skin, in muscle, and in the spinal cord, the connective tissue in all these parts having undergone the same mucoid retrogression. Of the remaining cases he said that all were adult women, and in all the change had followed confinements. In none was there any evidence of the existence of syphilis. In all the skin was dry, rough, and translucent. They were all lethargic and slow in speech and movement. In two the mental condition had advanced to aberration. In all the temperature was below the average; in one case now under care it was 93° F., and in another case under Dr. Harley's care there was mental disorder and lowered temperature. The urine was slightly albuminous in three of the cases. He attributed the nervous enfeeblement to the padding of the peripheral extremities of the cutaneous nerves by the altered tissue, and compared the effects to those produced by varnishing the skin. Several photographs and morbid specimens were shown in illustration.

Professor SANDERS (of Edinburgh) said that he had observed similar cases at various intervals, the last being about three years ago. They all presented well-marked clinical features not to be mistaken. He only had a clinical picture of them, for they all passed from his notice before they terminated. He was greatly interested in hearing the clinical features so ably sketched, and also to find the nature of this affection (to which he had never been able to give a name) so well ascertained, and its symptomatological features brought into such harmony with its pathological. All his cases occurred in adult women, and all eventually proved fatal. He inquired if the prognosis was always bad, and what measures (if any) could be taken for its relief.—Dr. GOODHART asked as to the condition of the brain in these cases. If the mental hebetude were due to the impairment of the nerves at their periphery, then there was no parallel to it in disease. He could understand such an effect following such a cause started in early life, before the brain was matured, for in that case its development would be arrested, as in the cretin. But in the adult, would not the brain still be sufficiently supplied from its own past impressions? In some respects—the mental condition, slow speech, and staggering gait—these cases resembled disseminated sclerosis, and he suggested that the cerebral symptoms might be due to the connective tissue thickening around the vessels of the brain.—Dr. DUCKWORTH promised to bring the issue of his case before the Society.—Dr. ORD, in reply, pointed out that Dr. Duckworth's case showed a tendency to mental aberration, and thought that these cases were of considerable interest psychologically. As to the history of children of these patients, the eldest child of the first case he had met with was now twenty-seven, but neither she nor her brothers and sisters showed any evidence yet of this affection. To Professor Sanders he said that prognosis was in all ultimately bad, but he had seen no case end fatally under six years, some lasting ten or twelve years. Treatment was of little avail. They improve in warm weather, grow worse in cold. Tonics are palliative only. To Dr. Goodhart's query he said that both brain and cord show perivascular thickening, but never to the extent found in sclerosis. As to the inapplicability of the theory of impaired peripheral nerve function to the case of adults, he thought this must be matter of opinion. He pointed out that perception was perfect, but slow; and this indicated peripheral rather than central derangement. The maintenance of perfect health of the nerve-centre depends on the stimulation it receives from the periphery.

Dr. F. TAYLOR read notes of a case of Empyema, in which portions of ribs were excised, contributed by himself and Mr. Howse. The patient, a girl six years of age, came under treatment in June, 1877, with a history and physical evidence of a recent pleurisy on the left side, partially cured. After a time a rise of temperature, local tenderness, and increasing dulness, pointed to accumulation of pus. There was also diarrhœa. An exploratory puncture having confirmed the diagnosis, the pleural sac was opened, and ten ounces of fetid pus escaped. Tubes were inserted, and the wound dressed antiseptically. After a month or two, the removal of the tube being followed by closing of the wound and signs of reaccumulation, it was decided to give freer vent by excising a portion of rib. This would allow, also, of more complete retraction of the chest-wall. An incision was made at the site of former operation, and about an inch of the seventh and eighth ribs removed, the periosteum being previously dissected off. The thickened pleural lining was then freely incised and drainage-tubes inserted. It was found that the ribs at seat of operation, and also the ninth rib, were the seat of ossific outgrowths. Considerable improvement followed; but again, in the course of about two months, the temperature rose. A small sinus was now only perceptible, and this speedily closed up. But diarrhœa set in, and albuminuria appeared, and it was not thought well to interfere further. The child died about a year later from lardaceous disease. It was then found that the empyema cavity reached the apex of the pleura; the membrane was very dense; and there was a little pus in the cavity. A bony bridge united the sixth to the seventh, and the seventh to the eighth ribs, and the point at which the seventh rib had been divided could not be found. There was purulent peritonitis, and lardaceous disease of liver, kidneys, and intestines. The authors referred to a recent paper on the subject of rib excision in empyema, abstracted in the *London Medical Record*. In this case the rapid repair of the divided parts frustrated their efforts to keep up drainage, and it was suggested that periosteum should be removed and not simply stripped off the bone; and also that the thickened pleura should be more freely removed. The only objection to such measures would be the comparatively slight one of division of intercostal nerves and vessels.—Dr.

DOUGLAS POWELL presumed that the object in view in removing portions of rib was to get a sufficiently large opening for free evacuation. In a case now under his care at Middlesex Hospital some such measure as this would have to be resorted to. It was a case in which a cavity in the lung had been laid open, and daily there was increasing difficulty in maintaining a free passage. Would this be sufficiently effected if a portion of rib were gouged out as suggested to him by Mr. Marshall? He would fear that in that case granulations would rapidly spring up and close the orifice. In the case just read was there any special reason for not again opening up the wound and removing the portion of periosteum exposed?—Dr. TAYLOR said that the object of the operation was both to evacuate the pus freely and also to allow of more complete retraction of the chest wall. Gouging would be less effectual, owing to the readiness with which repair would take place. Further interference in their case was barred by the fact of the presence of lardaceous disease.—Mr. HOWSE thought that gouging would not suffice, owing to the rapid formation of granulations, and he did not think it would be a good operation. Excision of a portion of rib was very simple and easy. They did not proceed further for the reason stated by Dr. Taylor, but he believed that the cavity of the empyema had undergone considerable contraction.

The Society then adjourned.

Reviews and Notices of Books.

Real-Encyklopädie der Gesammten Heilkunde, Medicinisch-Chirurgisches Handwörterbuch fur Praktische Aerzte. Herausgegeben von Dr. ALBERT EULENBERG. Wien.: 1880.

THE second quarter of the present century was marked in medical literature by the extensive dictionaries of medicine and surgery which appeared in France and Germany, and which the progress of medical science during the third quarter of the century has well-nigh rendered obsolete. The close of this period has witnessed the publication of encyclopædic "systems" of medicine and surgery which in part have taken the place of the still more ponderous dictionaries. The latter, however, in France, are in course of re-issue in new forms, and a fresh work of similar character, under the above title, is about to appear in Germany under the editorship of Professor Eulenberg of Greifswald, whose name is sufficient guarantee for the care and ability with which his part of the undertaking will be performed. Amongst the ninety contributors announced are, in general medicine and pathology, Birch-Hirschfeld, Eichhorst, Ewald, Klebs, Mosler, Oberneier, Riess, Rosenbach, Weigert, and Züzler; in psychology and neuropathology, Sceligmuller, Sander, Rosenthal, Remak, Pick, Benedikt, Berger, and Arndt; in dermatology, Auspitz and Kaposi; in surgery, Albert, Busch, Gurlt, Küster, Vogt, and Wolff; in gynæcology, Bandl, Greulich, Kleinwächter, &c.; in ophthalmology, Hirschberg, Hock, Klein, Reuss, Schmidt-Rimpler; in otology, Lucae and Politzer; and in physiology, Landois. It is to be completed in about ten volumes, each consisting of ten parts, and of the latter the first is now before us. It contains an excellent series of articles from AA to AC. The chief space is occupied by an admirable account of "Abdominal Typhus," by Züzler, of Berlin, well written and well illustrated. Among the figures is one of Liebermeister's apparatus for applying cold, which is, we think, unknown in this country. It consists of a hollow water-sheet, in which the patient is enveloped, and through the cavity contained between the two layers of the sheet, water of the desired temperature is allowed to flow. Among the other articles is one on purgatives ("Abführmittel"), by Lewin, and on "Abortion" in its medical aspect, by Kleinwachter, and in its medico-legal relations by Hofmann. "Abscess" is a clinical article by Albert.

The type is clear and not too small. The words at the head of the articles are in small black letters, but they are not sufficiently different from the other type to be readily distinct: the commencement of an article is easily overlooked. We would strongly recommend, even at the loss of uniformity, either the adoption of a blacker type for these words, or else that a line's space should be left between each article; at present there is none. The work promises to be a most valuable addition to medical literature.

Le Pansement Antiseptique exposé spécialement d'après la Méthode de Lister. Par le Chevalier J. N. NUSSBAUM, Professeur de Clinique Chirurgicale à l'Université de Munich. Traduit sur la deuxième édition Allemande, par le Dr. E. De la Harpe. Paris: Baillière et Fils. 1879.

ALTHOUGH Mr. Lister has many followers in this country, it is well known that his method of antiseptic treatment has been received with more enthusiasm on the continent.

This work of Professor Nussbaum is widely known, and is now in its third German edition. One chapter is devoted to a very useful description of the various preparations of carbolic acid, boracic acid, &c., used in surgery, and their cost. Then follow the details of several cases treated in hospital to illustrate the methods of employment of the different antiseptics; these cases are well related, and we are not dazzled by histories of wonderful recoveries, the author's object being simply to instruct in the use of certain forms of dressing. The question of the use of antiseptics in military surgery is then briefly discussed, and the employment of a compress of salicylic-acid wool as a first dressing is strongly urged. Carbolic infection is also described, as well as so-called "carbolic-acid eczema," which Nussbaum holds to be really due to the resin or paraffin in the dressings. But of main interest in the book are the wonderful statements of the result of Lister's method in Nussbaum's hands. Previous to 1875 the antiseptic system had not been tried, though carbolic acid, chlorine water, and other disinfectants had been freely used. And this was the result: "Pyæmia struck down all compound fractures, and nearly all amputations. More than one physician asked if it was right to operate in such an infected hospital. In 1872 hospital gangrene was added to pyæmia, and became more and more destructive until, in 1874, 80 per cent. of the cases of wounds or injuries were attacked by it. Erysipelas was met with in almost every bed. Every patient had one or two attacks of hospital gastritis." Not one of his students had seen in the hospital an instance of union by first intention. The rare cases of amputation that were not fatal remained in the hospital from 140 to 160 days; they had two or three attacks of erysipelas, and were so weakened that they could not for a long time leave their bed. In 1875, without any change in the wards, the nursing, the diet, or the surroundings, Lister's antiseptic treatment was introduced, and "every dressing, small or great, was made strictly in accordance with Lister's rules." From that day there has not been "one case of hospital gangrene, of pyæmia, or of erysipelas; in a word, the hospital has been transformed. A case of amputation never stays longer than thirty or forty days in the ward, and some have been discharged completely cured and robust at the end of fourteen days, having been dressed only four times." The mean duration of the stay of patients in the hospital has not been sensibly lessened, because severe injuries and compound fractures, which formerly died in from eight to ten days, now require from eighty to one hundred days for their recovery. "The rate of mortality has fallen one half, and those seen on the post-mortem table are mostly suicides, men crushed by a fall, the old, the phthisical, and the cancerous.....Thanks to antiseptic precautions, operations are now undertaken without danger

which one would not have dared to do with the open dressing; for instance, incision into joints, and Ogston's operation for genu valgum." What wonder that Nussbaum is enthusiastic, and that he holds it to be, not a matter of choice, but of stern duty for every surgeon to make himself thoroughly familiar with the principles and details of Listerism, and carefully practise it in every case. For while other methods of treatment *may* prevent secondary inflammation of various kinds, Lister's is certain—so says Nussbaum—to do so, if thoroughly carried out! This translation will make the pamphlet accessible to a number of English surgeons, and we hope that they will avail themselves of the opportunity of learning exactly what our German *confrères* are accomplishing with, and thinking of, "Listerism."

Observations on Contraction of the Fingers. Also, on the Obliteration of Depressed Cicatrices. By WILLIAM ADAMS, F.R.C.S., Surgeon to the Great Northern Hospital, &c. London: J. and A. Churchill. 1879.

THE two essays which Mr. Adams has published together have been presented to the profession before in a less complete form—the one at the Medical and Chirurgical Society, the other at the British Medical Association. Each of them recounts Mr. Adams's success in the treatment of troublesome affections by subcutaneous methods. Dupuytren's contraction of the fingers is fully dealt with, its exact nature described, and the influence of gout in its production insisted on. The chief features in Adams's operation are two—the subcutaneous division of the tense bands of fascia in several places, and the immediate extension of the fingers. Several illustrative cases are recorded. It is a pity that, by an incorrect use of the words "inner" and "outer," as applied to the little finger, some ambiguity has found its way into the text, the ulnar border of that digit being more than once spoken of as the "outer border." The republication of these essays will attract fresh attention to the subjects, which are well worth the attention of surgeons.

Manual of Practical Anatomy. By J. COSSAR EWART, M.D., F.R.C.S.E., F.R.S.E., Lecturer on Anatomy, School of Medicine, Edinburgh. With outline plates, engraved by W. Ballingall: The Upper Limb. London: Smith, Elder, and Co. 1879.

THE distinguishing feature of this manual is the absence of diagrams in the text, and the outline drawings at the end of the volume, which are intended to be filled in by the student from his own dissection. There can be no doubt that if students will adopt the method sketched out by Dr. Ewart in his introduction—that is, will prepare for their work overnight, and make drawings of their dissections as they go along, to be kept for reference when reading up their anatomy afterwards—they will learn their work far more pleasantly and far more efficiently than they do now when they rely so much upon woodcuts and "tips." The outline drawings are excellent, and, if used as intended, will prove of great service. The text is clear and brief; indeed, its only fault lies in being too brief in places. The book is printed well on good paper; but it seems a pity that it is being brought out in parts.

OUR LIBRARY TABLE.

The Quarterly Journal of Microscopical Science. No. LXXVI. October, 1879. London: Churchills.—This part, which completes the nineteenth volume of the New Series, contains four papers:—1. On some Points in the Early Development of the Common Newt, by W. B. Scott and Henry F. Osborn, of Princeton. 2. The Structure of Haliphysema Tumanowiczii, by E. Ray Lankester. 3. An account of Lithamœba Discus, nov. sp., one of the Gymnomyxa, by E. Ray Lankester. 4. On the Structure of the Vertebrate Spermatozoon, by Heneage Gibbes, M.B. Messrs. Scott and Osborn found picric acid the best staining agent for triton embryoes. They criticise some points of Götte's paper on the Bombinator, and describe in detail the formation of the epi-, hypo-, and meso-blast, the notochord, the body cavity, and the somites of the head. They observe that the marked divergences from the batrachian type which the newt exhibits point to the conclusion that the urodeles and batrachians have been seperated for a very long period, and it is interesting to observe that in those cases where the divergence is other than a mere matter of detail it leads towards the lamprey, and through that to the amphioxus. "The opinion seems to be gaining ground that some such form as the lamprey is the point towards which the amphibia, the elasmobranch, ganoid, and dipnoic fishes converge." The conclusions arrived at by Mr. Gibbes in regard to the development of the spermatozoa are as follows:—That the head of the spermatozoon is enclosed in a sheath which is a continuation of the membrane surrounding the filament and connects it to the body, acting, in fact, the part of a mesentery. The substance of the head is quite distinct in composition from the elliptical structure, the filament, and the long body, and it is readily acted upon by alkalies. These reagents have no effect however, on the other part, with the exception of the membranous sheath. This elliptical structure has its analogue in the mammalian spermatozoon. In the one case the head is drawn out as a long pointed process, in the other it is of a globular form, and surrounds the elliptical structure. Lastly, the motive power lies in a great measure in the filament and the membrane attaching it to the body.

Children's Lives, and How to Protect Them. By WILLIAM LOMAS, M.D., M.R.C.P., &c. London: Sampson Low and Marston, Fleet-street. 1879.—The author, in his preface, quotes Dr. Farr's statement, that "the death of a child is an unnatural event," and adds, "It is an unquestionable fact that mismanagement is the chief cause of this large and unnecessary mortality." The object of this small work is to guide parents in the treatment of the more common diseases of children; and judging from the broad and matter-of-fact way in which the subject is treated, the book should be useful to those in the colonies and elsewhere who are for the time out of the reach of medical advice.

The Practitioner for October.—The first article is a continuation of Dr. Murrell's observations on the value of small doses of sweat-excitors in checking the night-sweating of phthisis. In this paper picrotoxine is described as of especial value. Dr. Ringer contributes a short account of the relative action of duboisia and atropia, when given internally. The value of glycerine in the treatment of hæmorrhoids is described by Dr. Young, of Florence; that of cotobark in the diarrhœa of phthisis by Dr. Burney Yeo; and Dr. Francis Imlach describes certain apparatus for the automatic application of electricity in some forms of paralysis.

The Birmingham Medical Review, October, 1879.—Under the able editorship of Dr. Saundby, the new series of the *Review* maintains a high standard of interest and usefulness. The reviews are characterised by ability and independence, and the original articles are of considerable value. Among the contents of the present number are an excellent analytical review of a series of recent papers on the treatment of genu valgum, reviews of Haeckel on Evolution, Gowers on Hodgkin's Disease, Fothergill on Heart Disease, Dowse on Syphilis, and some minor works. The original communications include an Introductory Address, delivered by Dr. Sawyer at Queen's College, Birmingham; the second of Dr. Bassett's Ingleby Lectures on Pregnancy and its Diseases; an able article by Dr. Saundby on the Functional Stage of Granular Kidney; and one on Bichloride of

Ethedine as an Anæsthetic. Abstracts of some important cases in medicine and pathology conclude the number.

The Rivista Medico-Farmaceutica Florida. No. 1, September, 1879.—The first number of this latest addition to medical serial literature contains several articles of value: On the Origin of Bright's Disease, by Dr. Leopold; on a case of Tetanus treated successfully with Curara and Chloral, by A. Brian; and a paper on Eserine, by Dr. Jurkowski.

Luxurious Bathing. A Sketch. By ANDREW W. TUER. Illustrated with twelve folio etchings, initials, &c., by Sutton Sharpe. London: Field and Tuer; Simpkin, Marshall, and Co. 1879.—A splendid specimen of modern printing, binding, and publishing. The etchings are remarkably fine, and the garb in which they are presented to the reader is sumptuous beyond conception by those who have not seen the book. Apart from its merits as a literary and artistic work it will serve admirably as a present.

DISTRIBUTION OF PAUPER LUNACY IN ENGLAND AND WALES.

ACCORDING to the recently issued Report of the Commissioners in Lunacy, no less than 62,107, or nearly 89 per cent. of the 69,885 persons of unsound mind registered on 1st January last were pauper lunatics. With regard to the 7778 private lunatics, the Report affords no means for locally distributing them in accordance with their previous residence. The variations in the local incidence of insanity may, however, be very safely inferred from the recorded numbers of pauper lunatics chargeable to the various poor-law unions of England and Wales. These variations are, moreover, sufficiently well marked to afford material for the consideration of some of the conditions which govern the proportion of recorded lunacy in different populations. The Lunacy Commissioners' Report tells us that the average proportion of the registered insane was on the 1st January last equal to 2·78 per 1000 of the population; of this, 2·47 per 1000 represented the pauper lunatics, while the proportion of private lunatics was 0·21. It is the local distribution of the pauper lunatics that we propose at present to discuss. It may be stated, in the first place, that this proportion of pauper lunatics in England and Wales has steadily increased from 1·61 per 1000 of the population in 1859, to 2·47 in 1879. The real interest of this increase centres in the elucidation of how much of it is due to increase of lunacy, and how much to the more general registration of cases of lunacy, or to the larger proportion of them that are treated as pauper cases. Pauper lunatics, as recorded in the tables of the Lunacy Commissioners' Report, are of three classes, those in lunatic asylums, those retained in workhouses, and those residing at home with relatives and others. All these three classes are included in the proportions of pauper lunacy; it is clear, therefore, that the increasing tendency in recent years to treat pauper lunatics in asylums ought not to affect either the varying proportions from year to year, or in different localities; there is, however, very good ground for believing that the increase of accommodation for the asylum treatment of the insane has the invariable tendency to increase the proportions of the registered insane. In the metropolitan registration division the proportion of pauper lunatics to population on Jan. 1st last was equal to 3·54 per 1000, against 3·47 on Jan. 1st, 1878. This is a higher proportion than prevails in any other part of England or Wales, and it is worthy of note that it is the metropolis which has provided by far the largest proportional amount of asylum accommodation, if we take into account the asylums for imbeciles at Leavesden and Caterham. The highest proportions of pauper lunacy in the English registration counties on Jan. 1st last were 3·05 per 1000 in Berkshire, 3·06 in Warwickshire, 3·38 in Oxfordshire, 3·40 in Worcestershire, and 3·51 in Wiltshire. It will be noticed that most of these counties are mainly agricultural in character. The following counties showed the smallest proportion of pauper lunacy:—Durham 1·34, Staffordshire 1·53, Yorkshire 1·67, Derbyshire 1·85, Cornwall 1·94, and Northumberland 1·96. In each of these last-named counties a large proportion of the male population is engaged in mining operations. It would appear from a comparison of these pauper lunacy rates in these agricultural and mining counties that the proportion of the registered insane is in inverse proportion to the educational condition and general intelligence of the population. The evils of urban aggregation and defects of sanitary condition in the mining districts do not seem such important factors in the proportion of insanity as the mental depression and inactivity which, together with low diet, prevail in agricultural districts. It is worthy of note that the proportion of pauper lunacy in Lancashire, where the amount of asylum accommodation is far smaller than it is in the metropolis, did not exceed 2·22 per 1000, whereas in London, as we have before stated, it was 3·54 per 1000. It will be interesting to inquire how, and at what periods, the excess of more than 50 per cent. in the proportion of registered pauper lunacy in the metropolis, compared with that in Lancashire, has accumulated.

Analytical Records.

PATENT COMPRESSED EFFERVESCENT.

(MESSRS. WHEELER & CO., 7, GEORGE-YARD, FENCHURCH-STREET.)

THIS preparation presents the compound known as citrate of magnesia in a novel and convenient form—namely, in that of hard cubes of about ⅞ in. side, each cube being sufficient for a tumblerful of effervescent drink. In this form the evolution of the carbonic acid, instead of taking place tumultuously, as in the ordinary sherbets and citrate of magnesia preparations, proceeds, from the hardness of the material, gradually and steadily, so that the tumblerful of liquid can be drunk leisurely. We need hardly again point out that all articles sold as citrate of magnesia do not strictly deserve that appellation, consisting as they do of bicarbonate of soda, citric acid, and a little sulphate of magnesia.

THE PERFECTED COD-LIVER OIL.

(MESSRS. ALLEN & HANBURYS, PLOUGH-COURT, 37, LOMBARD-STREET.

Messrs. Allen & Hanburys have as nearly as possible succeeded in depriving cod-liver oil of its nauseating smell and taste. They present in their "perfected" article the oil in a beautifully bright and but very little coloured state. It is said to contain the whole of the medicinal and nutritive properties belonging to the ordinary oil. Many persons to whom the taste of the oil has hitherto been an obstacle will doubtless be able to take it in this its more perfected form.

ZOEDONE.

(MESSRS. R. EVANS & CO., WREXHAM.)

This elegantly got-up effervescent drink is an excellent vehicle for phosphate of iron, its most important constituent. It is practically free from ferruginous taste, and is a bright, sparkling, and pleasant non-alcoholic beverage.

FELLOWS' COMPOUND SYRUP OF HYPOPHOSPHITES.

(MESSRS. S. M. BURROUGHS & CO., 8, SNOW-HILL.)

Fellows' Syrup contains the hypophosphites of iron, quinine, strychnia, manganese, lime, and potash,—the strychnia amounting in a dose of one drachm to $\frac{1}{16}$ gr. The preparation therefore includes a number of powerful nervine tonics. These are almost completely dissolved in the syrup. The reaction of the preparation is practically neutral—an advantage in many cases where the acid solutions of quinine and iron are objectionable or inadmissible. The compound is skilfully prepared, and the difficulties of keeping the remedies which it contains in solution, and in a form in which they are not liable to change, have been very successfully overcome.

THE LANCET.

LONDON: SATURDAY, OCTOBER 18, 1879.

IF the students of our provincial medical schools do not henceforth compare favourably with those of the metropolitan ones in the examination of the Royal College of Surgeons of England and of other bodies it will not be because sound principles of study and of conduct have not been commended to them in the introductory lectures which have initiated their studies. At Birmingham, Leeds, Liverpool, Sheffield, Manchester, Newcastle-on-Tyne, and other schools, the work of the session has been inaugurated with lectures the perusal of which will afford profit to practitioners as well as to students. It would occupy no little space to merely enumerate the topics treated of at more or less length in these very able addresses. The only misgiving we have is whether some of them were not a little too technical, too extensive and high-pitched for students, many of whom are at the threshold of medical knowledge. Misgiving particularly applies to cases in which the lecturer is a specialist, and dives into the most recent discoveries in his own specialty for illustrations of the art and science to which he is urging devotion. Be this as it may, we have perused these addresses with much pleasure, and risen from the perusal with the conviction that in the provincial schools there are indications of an earnestness on the part of teachers which is likely to make itself more and more felt in the future in proportion as teaching becomes more free and open, and the results of examinations give impartial evidence of the distribution of teaching power. Several of the teachers, particularly Dr. GEORGE HEATH of Newcastle, and Dr. JAMES SAWYER of Birmingham, alluded to the practice of the English College of Surgeons of publishing the statistics of its examination. Dr. HEATH, on the opening day, expressed satisfaction at the improved position of the students of the school of Newcastle-on-Tyne in the last pass-lists of the College, and the Registrar of the School in his report expressed the determination of the Council to be still more strict in requiring students to attend lectures, and in refusing to allow students to go in for examination before any of the licensing boards prior to satisfying the lecturers of the school of their fitness to do so. Dr. SAWYER, of Birmingham, showed that the Birmingham school has abundant reason to be proud of its work as illustrated in the same lists, showing that whereas at the College Primary Examinations the average rejections of London students are 30·3 per cent., and of provincial schools 32·3 per cent., the percentage of rejections of Birmingham students is only 15·7. At the Pass Examinations Birmingham appears in an equally satisfactory light, for whereas the average rejections of metropolitan students was 31·3, and those of the provincial schools 35·6, those of Birmingham students are only 17·5. We can all see the disadvantages of the multiplicity of medical schools. Here at least is the advantage in the rivalry to do good work, to turn out men that can stand the test of examinations by men who have not taught them, and the later and yet graver test of work in public and private practice. Mr. SNELL, at Sheffield, brought out this point well in an able address, which in its earlier part was perhaps open to the criticism of being too specially ophthalmological. We have not time to allude to many other questions raised in the addresses. The critical state of our examining system and the inertness and inefficiency of the Medical Council, of course, did not escape observation and severe reflection. There is evidently an expectation that these points will be dealt with ere long, and that students will soon have the advantage of a fair, complete, uniform examination in each division of the kingdom, and a better assurance than at present that no lazy and unworthy member of their body will be able to get through a wide gate into a profession of which he is unworthy, and which is eminently a calling for the earnest and the industrious.

TWO communications to the late Medical Congress at Amsterdam had for their subject the pathology and symptoms of Bright's disease; one, by ROSENSTEIN, contained much that is familiar to English pathologists, and some conclusions which will probably not command immediate assent. His conclusions were—(1) The anatomical lesions in the kidneys which determine the group of symptoms, described for the first time by BRIGHT, always affect the parenchyma as well as the connective tissue. There is no such thing as a nephritis exclusively interstitial, or a nephritis exclusively parenchymatous. Experimental and clinical facts agree in showing that in a true diffuse inflammation of the kidneys these two elements are affected from the first. (2) The final product of diffuse inflammation is the pale kidney and the red granular kidney. They constitute, from an anatomical point of view, the atrophied kidney, and only differ in that the parenchymatous affection is the more pronounced in the first, the interstitial affection in the latter. In their clinical aspect they are distinguishable by the character of the urine. The symptoms of atrophy are common to the two forms. (3) Clinical observation makes it probable that the red granular kidney, commonly termed "primitive cirrhosis of the kidney," is preceded by a stage of tumefaction. (4) The clinical description given by BRIGHT refers especially to the pale granular kidney, and both anatomical and clinical facts make it certain that in this modification the morbid process passes through two stages.

The second paper, by Professor SEMOLA, of Naples, dealt with the subject in a still wider pathological aspect. He called attention to his own observations, made as long ago as 1850, on the influence of diet on the quantity of albumen in the urine, showing that a nitrogenous diet increases, and a non-nitrogenous lessens, the quantity of albumen. This was the starting-point of a series of researches which led him to the conclusion that it is necessary to direct attention not only to the renal lesions, but at least equally to the general impairment of nutrition, in consequence of which the albuminoids are not perfectly assimilated or oxidised. This idea is confirmed by a fact, well-known but, according to the author, hitherto misconceived—the diminished quantity of urea, due, he thinks, to the diminished formation of urea in chronic Bright's disease. The diminished forma-

tion he ascribes to the defect or suppression of the functions of the skin. From this defect two chemical disturbances necessarily result: on the one hand, the defective assimilation of the albuminoids; on the other, their defective combustion and the diminution in the formation of urea. In other forms of albuminuria than that of Bright's disease there is not the same relation between the diminution or the formation of urea and the transudation of albumen, and hence it is of the greatest importance to separate strictly these different forms of albuminuria. In the others the formation of urea may be lessened in consequence of general disturbance of nutrition, but the course of the former is independent of the albuminuria which may exist. It is only in the late stage of these diseases that the urea in the urine becomes lessened by defective filtration. This is a mechanical effect, and immediately the urea accumulates in the blood, with all its consequences.

In Bright's disease, properly so-called, the urea is lessened in the urine as a result of two causes. In the first period of the disease there is a diminution which is due to the defective combustion (general disturbance of nutrition and alteration of the functions of the skin); later on there is a secondary defective elimination of urea, and accumulation in the blood. The effect of exclusive attention to the anatomical condition has led to the neglect of the general and chemical aspect of the disease, and hence the paradoxical conclusion of clinical unity and anatomical multiplicity. The occurrence of albuminuria may depend on the three physiological factors which preside over the renal secretion—namely, chemical conditions of the blood, degree of pressure, and conditions of the histological elements in the filtering apparatus. In consequence, there are the three forms of albuminuria — dyscrasic albuminurias (due to excess or alteration of the albuminoids of the blood), mechanical albuminurias, and irritative albuminurias (i.e., those due to local alterations in the kidney, or due to the irritation of agents which act upon the kidney). These three species of albuminuria correspond to the anatomical state of the kidney in so far that if each of these three abnormal conditions has been of short duration and transient, the anatomical condition of the kidney may remain normal, or it may be modified by a morbid process, and quickly return to the normal condition; or, if the albuminuria is persistent, the anatomical state of the kidneys undergoes a slow alteration, and a special lesion results from the action of each cause—a lesion which is always in constant relation to each of the factors which have so modified the renal function as to determine the occurrence of albuminuria.

WE have, on more than one occasion, lately endeavoured to reawaken the strangely declining interest in the health and diseases of children. Much mischief has resulted from the use of that very unsatisfactory phrase, "the diseases of childhood," which, if it had any significance, would imply that certain maladies, and these only, affected the young. The facts we know to be wholly at variance with this presumption. It is true that special affections, to which the imperfectly developed organism is peculiarly liable, mainly occur in childhood. Some of the number can scarcely occur in riper years; but outside this limited class of morbid conditions there lies the vast catalogue of diseases which not only may, but do, attack young children, and appearing in physiological conditions differing in many important particulars from those of adult life, put on special appearances, and set up peculiar disturbances, of which the ordinary observer perhaps takes too little account. The treatment of sick children forms a large part of the business of the general practitioner. This is as it should be, but it follows that he is the person to whom we must look for whatever light can be thrown by way of explanation on the notorious circumstance that of late years the study of disease as it occurs among children has been neglected beyond precedent, and, as far as we can see, without cause or excuse.

Can it be possible that the enterprise of research in this wide and rich field of pathology has been abandoned to specialists? Such a course would be most regrettable. In addition to the circumstance to which we have just alluded—namely, the very large proportion of work this branch of practice involves, — there is the fact that it is among children the awakening of inherited disease takes place, and here, if anywhere, it can be stamped out. Then, again, the young organism being as yet for the most part unscarred by active disease, morbid phenomena and their effects can be investigated under conditions highly favourable to their elucidation. Further, the action of remedies is more simple and direct in the treatment of children than when employed in the case of an adult. These and a variety of considerations which will suggest themselves would certainly seem sufficient to induce any patient and earnest practitioner to devote a large part of his time and thought to the province of which we speak. How comes it to pass that the evidence of good work being done in this department is wanting?

There are under-currents of influence in the world of science as elsewhere, and it may be that something we do not recognise has diverted professional attention away from the quarter indicated. Are we to suppose that the salutary reaction against needless specialties and special hospitals, which we are glad to have elicited some few years ago, exerted an influence beyond its legitimate area, and led to the neglect of some of the subjects which, however unfitted to form the bases of specialties, were of the highest interest and importance in themselves? If this were the fact, it would be an incident much to be lamented. Specialties of practice are one thing, and in the main, we think, undesirable; specialty in study is quite another matter. There are the strongest reasons why the diseases of children should not be considered or represented as a specialty. Not only are medical men generally fully competent to treat disease as it occurs among children, but such cases form the bulk of their practice. Meanwhile it should be understood that the class of maladies affecting children by preference, together with the modifications of morbid action induced by the simplicity and crude state of the child's organism, form a topic worthy of the most earnest attention.

We venture to make a pointed appeal to our readers in connexion with the subject of the present remarks. Glancing through the literature of medicine, the papers read before the Societies, the cases noted in hospital practice, and the clinical lectures delivered in the wards for educational purposes, it is impossible not to be impressed with the paucity of attention bestowed upon the maladies of child-life, and the little interest they seem to arouse. It would be well if

this unsatisfactory state of matters could be amended. The public health demands that the entail of disease should be cut of, and this can only be accomplished by making the heir a party to the procedure. Children must be treated expressly for hereditary maladies, and in their persons the seed of the evil must be exhausted or destroyed. The success achieved by science in dealing with the once terrible contagion of small-pox ought to act as a strong incentive to further effort in the same direction. Some years ago there were indications of a movement to attack other diseases, which have come to be regarded as inevitable, in the same or a similar fashion. It was thought that by timely measures to obliterate the physical bases of a tendency to disease, or to eliminate the negative germs which contagion might hereafter impregnate, the so-called "seeds" or "germs" of constitutional disease could be exhausted. This may have been an erroneous presumption, but it was a sign of life and interest in an all-important subject that such a suggestion was made. It would be well if equally significant tokens of enterprise were now forthcoming. The men who made the diseases of children a special study have lapsed into silence, if not inaction; and however good the daily work done in this department by the general body of practitioners may be, the profession is not enlightened by their discoveries, or placed in possession of any improvements which may have been effected in treatment. If these defects can be repaired, it will not be without result as well as reason that we have called attention to a subject which seems to have wellnigh dropped out of public thought.

Annotations.

"Ne quid nimis."

HOSPITAL ACCOMMODATION FOR INFECTIOUS DISEASES IN LONDON.

THERE is a very serious probability that London, when the next great epidemic comes upon her, will fall between two stools, in consequence of the Poor Law Act of 1879. We have already remarked on the permissive character of the wording of the most essential clauses of the Act. Permissiveness in legislation is at least an anomaly, but when it occurs in Acts that have life and death bearings, it is simply intolerable and discreditable. It is so with the Act in question. It contains clauses empowering the Local Government Board to contract with vestries for the reception of non-pauper patients. It says in the fifteenth clause, the Board "*may* contract with vestries for the reception of non-pauper patients." The suggestion of this clause is, that the Metropolitan Asylums Board shall become the great sanitary authority of London for providing hospital accommodation for non-pauper patients. This is a great suggestion, perhaps a right one. But what are we to think of a strong "sanitary" Government expressing such a suggestion in a permissive way? Mr. Gulsworthy, at the last meeting of the Asylums Board, very properly brought the vague language of the Act under the notice of his colleagues, who naturally object to act until they know whether they are required to do so by the law. The president of the Local Government Board has said to a deputation that "may" meant "shall." But it is beyond the power even of the Local Government Board to alter the meaning of the English language; and one cannot help asking, if "shall" was meant, why was "may" put? We know—as Mr. Gulsworthy said—that the vestries will do nothing till it is too late. They will lock the stable door when the horse is stolen—perhaps not then. The Asylums Board have moved to take the opinion of the Local Government Board on the meaning of "may." We grieve to have to confess to an entire want of respect for the authority of the Local Government Board on questions of plain English; and if this Act is not made quickly and clearly compulsory we predict a more complete breakdown in attempts to limit the spread of epidemics than has yet occurred, which is saying a great deal.

DR. ANDREW DUNCAN.

THE intelligence that this distinguished young surgeon had been dangerously wounded in the recent engagement before Cabul has been received with great regret by a large circle of professional friends. Dr. Andrew Duncan's career has hitherto been most brilliant. Educated at King's College Hospital, he held the appointment there of house-surgeon and registrar. At the London University, at the M.B. examination, he took the gold medals in medicine and midwifery, and the gold medal in surgery at the examination for the B.S. He subsequently studied at Vienna and Strasburg, and on his return to town obtained the appointment of medical tutor and pathologist to St. Mary's Hospital, which he held for several months, making many friends among the staff by his energy and excellent work. Finding the pursuit of practice in London distasteful to him, he determined to join the Indian Medical Service, although strongly dissuaded by his friends, who saw that a prosperous career lay before him in town if he would only be content to wait a few years. At Netley he greatly distinguished himself, taking the Parkes memorial medal for hygiene. Immediately after leaving Netley he was ordered out to India, and arriving there just at the outbreak of the Afghan war, was sent at once to the front, was with General Sir F. Roberts in the campaign of last year, and accompanied the same general in his rapid and brilliant march on Cabul, which has just been brought to a successful conclusion. We have no details as yet as to the nature of the wound, and how it was received. From the fact, however, of its being of a dangerous character, and received during the fierce engagement that took place when the heights were carried, we should gather that Dr. Duncan was doing his duty in the front, exposed to the hottest fire. We shall await with anxiety further intelligence as to the progress of his case, for the Army Medical Department cannot afford to lose a man of his high qualifications and calibre. In the meantime his friends must content themselves with the information supplied by the telegrams that "the wounded are doing well."

SPASMODIC STRICTURE OF THE URETHRA.

A DISCUSSION on this time-honoured subject has been carried on lately in the pages of a New York periodical—the *Hospital Gazette*—between Drs. Otis and Sands, which is of interest rather as a warning than otherwise. Dr. Otis has advanced the view that many cases of supposed organic stricture deep down in the urethra are really instances of spasm of the muscular fibres around the membranous urethra, induced by stricture in the anterior portion of the canal. This doctrine had previously been taught in France by MM. Verneuil and Folet. In America it excited little attention until Dr. Sands published a lecture, asserting that Dr. Otis's statements lacked substantial justification, and were dangerous, inasmuch as they led to unnecessary and even perilous operations. Dr. Otis replied, and lately Dr. Sands has circulated a small pamphlet briefly responding to him. It is to this paper that most interest attaches, for, while it is a tolerably successful defence, it at the same

time shows that Dr. Otis has not been so careful in the reports of cases in his previous paper as he should have been. It is impossible to conduct discussions upon modes of practice unless the most perfect reliance can be placed upon the reports of cases; but when we find a case of stricture reported and no mention made of the existence of a serious false passage, and another case stated to be of an "exactly similar character" to one from which it differed in all-important particulars, we can but receive other statements by the same author with the reserve which is fatal to discussion. Dr. Sands' paper also contains a caution to surgeons who are much engaged in the treatment of stricture. He states, "with authority, that three fatal cases of operation with the dilating urethrotome have lately happened in our city hospitals, two of which occurred last week in one hospital. In two of the cases mentioned, death took place from pyæmia within a week of the operation. In the third case death occurred from uræmia on the sixteenth day after the operation, which was performed for the division of an anterior stricture so slight as to be only detectable with a bulbous sound No. 24 F."

WARNING BOTTLES.

IT ought to be imperative on dispensers of medicinal appliances to pack them in a shape sufficiently distinctive to minimise the sources of accident. We have seen rat-poison sent out in white papers folded precisely as ordinary "cooling powders" for children are sent out. This is of course an opposite view of the error, the seller of poisons encroaching on the dispenser, but the latter has much need to mend his ways. We are not now speaking of chemists and druggists only, but of all who dispense. Preparations intended for external use ought invariably to be so characterised by being sent out in bottles of a warning shape and colour. It is not safe to rely on form or colour alone—the two danger signals should be combined. There are doubtless persons so obtuse that nothing can preserve them from folly. We have heard of a hospital patient who deliberately ate the ointment given to him, of course for "external use only"; but, setting aside such exceptional instances of stupidity, haste, a dull light, or what is commonly called "nervousness," may lead to mistake by even an intelligent person, when nothing beyond the lable on a bottle indicates its use. A recent case recalls attention to this subject, and we trust it will provoke the caution the danger requires.

SURGEON-GENERAL HAMMOND, U.S. ARMY.

WE learn with much pleasure that Surgeon-General W. A. Hammond, who was dismissed the United States army in 1864 by sentence of a general court-martial, has been restored to the rank of Surgeon-General, the proceedings of the Court having been annulled and set aside by an Act of the Legislature, after a careful and thorough examination of the case. In 1862, shortly after the outbreak of the rebellion in the United States, a Bill was passed by Congress to "reorganise and increase the efficiency of the Medical Department of the Army," which had been found totally incapable of performing the work which the emergency of the times demanded. To organise and administer the new system, Mr. W. A. Hammond was selected as being peculiarly fitted by his zeal, intelligence, and administrative ability. Mr. Hammond had served thirteen years as an assistant-surgeon, and at the time of his appointment was professor of anatomy and physiology in the University of Maryland. His promotion from the rank of assistant-surgeon to that of surgeon-general naturally created great discontent among the officers over whose heads he passed, and he was not supported, as he had a right to expect he would have been, by the authorities. Influence was brought to bear on the Secretary for War, and instead of the list of men selected by Mr. Hammond to carry on the work as medical inspectors under him being approved, men were put in, some of whom were untrained for their special work, and others hostile to the chief under whom they were to act. It is not surprising, therefore, that things did not go on satisfactorily, and in 1864 Surgeon-General Hammond was brought to a court-martial on charges chiefly relating to contracts for supplies and the acceptance of articles which were unfit for use. He was found guilty of the majority of the charges, and was dismissed the service. On his dismissal he went to New York, where he endeavoured to establish himself in practice, and, after many vicissitudes and a painful struggle, he succeeded to an extent beyond his expectations. Naturally feeling anxious to remove the stigma cast upon his character by his dismissal from the army, he exerted himself to have the proceedings of the Court revised, and to have the merits of his case fairly considered. This has accordingly been done, and the Secretary for War, being of opinion that the charges which had been brought against Mr. Hammond were not sustained by the evidence, recommended that the finding and sentence should be annulled and set aside. In accordance with this recommendation an Act of Congress was passed last year by which Mr. Hammond has been restored to the rank of Surgeon-General, but, at his own request, placed on the retired list. We sincerely congratulate him on the success of his efforts to vindicate his reputation. The Act of Congress has only now been published to the army in General Orders. A detailed statement of the grounds on which the Secretary for War founded his opinion has also been published, but we do not think it necessary to reproduce it. It may be sufficient to say that the case appears to have been very carefully investigated, and that the grounds upon which the ultimate decision was made are stated clearly, and appear fully to justify the course adopted by the Government.

"PUBLIC HEALTH AND PRIVATE INDIFFERENCE."

UNDER the above heading our contemporary, the *Pall Mall Gazette*, has touched the very core of the shortcomings in our sanitary administration, both public and private. It happily says of the optimist view which obtained a few years ago, to the effect that public health had ceased to be a party question, and that both Liberals and Conservatives were alike pledged to do all they could for it, that it would have been nearer the truth to say that the health of the nation had not yet risen to the dignity of a party question. "That it is not a party question is to be explained, not by the fact that both sides are agreed as to its importance, but to the fact that neither side cares about it." Our contemporary observes that there has been abundance of legislation on the subject, and implies that it is not legislation that is now wanted so much as the desire, among those whom it concerns, to give due effect to it. It is less sanguine than we are as to the beneficial effect of giving our health minister a position of great dignity in the Government, and observes that when we witness a leader of the House of Commons foiled in endeavouring to pass a Bankruptcy Bill, although supported by the mercantile community, we cannot hope that a cabinet minister would be more likely to succeed with public health measures, however beneficial, which most undoubtedly interfere with private convenience. We had in view, in approving Mr. Powell's suggestions, the improvement in the minister's powers as to matters of administration rather than of legislation. "The truth is," writes our contemporary, "that before sanitary improvements can be introduced on an adequate scale there must be a far more general appreciation than exists at present of the value of health and of the means by which health is maintained." This is the gist of the whole matter. "As yet we seem no

nearer than we were seven years ago to the passing of a Building Act applicable to the whole country, and in which shall be specified a minimum of sanitary requirements in the matter of drainage and ventilation which shall be exacted of every newly built house." In other words, our contemporary indicates the cardinal error of our sanitary legislation. We legislate, as a rule, to obviate evils which ought never to be permitted to occur. The sanitary Partington trundles her mop in face of the Malebolgian flood, heedless or ignorant of the fact that every new centre of population, and over the greater part of the kingdom, every newly built house may, and too commonly does, repeat the mischievous errors of the other houses, at the sweet will of the proprietors.

SCARLET FEVER IN KENTISH TOWN.

AT this season of the year scarlet fever fatality generally shows an increase in urban populations, and from recent weekly returns of the Registrar-General it appears that this autumn forms no exception to the rule. The fatal cases in the twenty large English towns have steadily increased in recent weeks. In London, although the weekly deaths from scarlet fever are still below the average for the season, corrected for increase of population, the local returns show in some neighbourhoods a decided tendency to epidemic prevalence. Since the beginning of September, 25 deaths from this disease have been registered in Kentish Town registration sub-district, which forms part of the sanitary district of St. Pancras. Of these 25 deaths, no less than 10 were recorded during the week ending last Saturday. Four of these 10 deaths occurred in three families living in one house, 16, Wellesley-road; a death from this disease also occurred in the same house on Sept. 25th last. This remarkable fatality affords the strongest evidence of the necessity for hospital isolation as the only means for controlling the epidemic prevalence of scarlet fever in densely populated districts like Kentish Town, where most of the houses are tenanted by two or more families. It would be interesting to know what efforts are being made by the local sanitary authorities of St. Pancras to promote hospital isolation, with a view to arresting this fatal epidemic in Kentish Town. It appears from the Registrar-General's last weekly return that on the 11th instant the Metropolitan Asylum Hospitals contained 254 scarlet fever patients, of whom 39 had been admitted during the week. At the end of the two preceding weeks the cases of scarlet fever under treatment in these hospitals were 253 and 265 respectively. It is satisfactory to find that the prejudice which at first prevented these hospitals for infectious diseases being turned to the best account is slowly but surely wearing away. The value of these hospitals should soon be apparent in the metropolitan mortality statistics of scarlet fever, but it is only during the last two or three years that any considerable number of scarlet fever cases have been received therein.

QUEEN'S UNIVERSITY IN IRELAND.

A MEETING of Convocation was held in Dublin on Oct. 16th, presided over by Sir Robert Kane, F.R.S. The report of the Committee of Convocation stated that the Queen's University had been successful in discharging its functions, and that it should not be dissolved, as proposed by the recent Act. The Committee had no grounds for apprehending the dissolution of the University, there being no precedent for such a measure; but if the recent Act, so far as it affects the Queen's University, were carried out, a serious injury would be done to the members of the University. Without expressing any opinion on the necessity for a new University in Ireland, the Committee thought the Queen's University should be left untouched; and they hoped even yet the first expression of the opinion of Convocation on the subject may have weight with Her Majesty's advisers. The report was unanimously adopted, and a resolution passed in accordance with the report of the Committee.

The election of two representatives of Convocation on the Senate of the University, in the room of the late Sir Richard Griffiths and Sir Thomas Larcom, took place on Friday, the 10th inst. The first vacancy occurred about a year ago; and Dr. M'Keown of Belfast, and Dr. Thornley Stoker of Dublin, became candidates for the vacant seat. The second vacancy took place recently, and for that seat Mr. Wilson of London, Barrister-at-law, was the only candidate. The voting was as follows:—Mr. Wilson, 247; Dr. M'Keown, 183; Dr. Stoker, 82. Mr. Wilson and Dr. M'Keown were declared duly elected. Although the medical number about half the graduates of the University, and the medical faculty is by far the most important, Dr. M'Keown is the only medical representative on the Senate; whilst four seats are filled by lawyers.

THE ZULU WAR.

A LETTER from our correspondent in Zululand puts us in possession of news to Sept. 7th. He reports the health of the troops generally to be steadily improving. Enteric fever, which had prevailed more or less in all the forts and detachments, has nearly disappeared, no fresh case having been admitted for some time. The sickness of the whole force in South Africa was now 4·5 per cent.; the fever and dysentery cases are lessening in numbers, and those in hospital are as a rule doing well. Fort Chelmsford and Port Durnford contain only a few cases, and will shortly be abandoned. At Durban 200 sick remain in the base and auxiliary hospitals, at Pietermaritzburg there are 100, and at Utrecht 50 in the field and base hospitals. At Ladysmith there are 10 officers and 98 men sick; of these 38 are gunshot wounds from Ulundi, all doing well. Some of these were originally very severe injuries necessitating amputation. Fort Crealock on the departure of the troops *en route* to Natal will be abandoned as a military station. A further detachment of non-commissioned officers and men of the Army Hospital Corps, under Lieutenant of Orderlies Horne, numbering over 100, had reached Ladysmith, to join the Bearer Company commanded by Surgeon-Major Hector, which has been ordered to join the force operating against Seccocoeni.

ADDENBROOKE'S HOSPITAL, CAMBRIDGE.

THE activity in medical matters which for years past has been so happily apparent in Cambridge has its last illustration in a discussion, warm but creditable, by the governors of Addenbrooke's Hospital, presided over by Dr. Paget. The subject of the discussion was a proposal to increase the surgical staff of the hospital by one—from three to four. The friends of this proposal took advantage of the resignation of Mr. Lestourgeon to make it. Mr. Lestourgeon retires from the duties of the surgeoncy, to the great regret of his colleagues, after having been three times elected surgeon for a period of twelve years. The proposal was urged on the ground that the general work of the hospital would be better done by having an additional member on the surgical staff, and Dr. Humphry further suggested that it would be well to have a colleague who could give some special attention to ophthalmic surgery and the administration of anæsthetics, which, it would seem, devolves at present, very unsatisfactorily, on anybody who can be got to do the duty. The office of chloroformist should be a separate one. Dr. Humphry expressed the opinion that at Bartholomew's and most of the London hospitals the staff was insufficient. It was said in the course of the discussion that there are over one hundred medical students in Cambridge. Dr. Latham expressed disapproval of the proposal, and Dr. Bradbury, in

a letter to the *Cambridge Chronicle*, does the same. Dr. Latham thought that all the necessities of the case would be met by the appointment of two assistant-physicians and two assistant-surgeons. But Dr. Humphry, with much magnanimity, argued for having no distinctions in the status of the members of the surgical staff. The proposal was carried, and it was also agreed that a committee should be appointed to consider the number and duties of the physicians of the hospital.

KILLED BY WILD BEASTS AND SNAKES.

THE returns of deaths by wild beasts and snakes in British India is appalling and discreditable. That little short of twenty thousand persons should have fallen victims to the ferocious vermin of an English dependency in a single year (1877) is past comprehension. It is true that more than ten thousand pounds is spent annually in the shape of rewards for the destruction of snakes and wild beasts, but either the effort must be insufficient or misdirected, or more would be done to remedy the evil. The question arises whether a systematic attempt has yet been made to rid the country of these formidable creatures by poison or otherwise. The claims and rights of sport cannot be recognised when they clash with the interests of human life, and they could of course only apply to the preservation of a select few of the larger "game." Snakes do not, happily, fall under this description, and the sportsman would be only too glad to be rid of them. We cannot help thinking the notion of exterminating the poisonous and destructive reptiles of India, as wolves have been exterminated in northern countries, by a reward per head, is puerile. When the evil is so great, it calls for a proportionately comprehensive remedy. Let a new commission of experts be appointed to consider whether it would not be possible to devise measures which should go more directly to the root of the matter, and perhaps, by dealing in detail with small districts, progressively destroy the eggs and nests from which these vermin come. The subject is one of such great and urgent interest that we cannot suppose public opinion either in India or at home, will allow it to remain much longer in abeyance.

THE ADVANCE ON CABUL.

WE have received from our Indian correspondent, by the last mail, the plan of the medical arrangements for the expedition to Cabul. They were laid down on the lines which were so successful in the late Afghan war, the *précis* of field medical arrangements, compiled under the direction of Surgeon-General Ker Innes, C.B., being adopted as the guide in working out the details of equipment, hospitals, transport, and distribution of *matériel* and *personnel*. Commencing with the Kurum force, Deputy Surgeon-General Townsend, Bengal Medical Service, remains with General Roberts as Principal Medical Officer, with Surgeon-Major J. H. Porter as second in command and in charge of the divisional field hospital. The base was Kohat, where a large stationary hospital had been established, and to which sick and wounded from the front could be transferred, the hospitals and rest depôts along the line of communications at the Peiwar, Shalafzan, and Ali Kheyl receiving them and evacuating to the base as transport permits. Surgeon-Major J. H. Hanbury, with the officiating rank of Deputy Surgeon-General, was to be responsible for the medical arrangements of Brigadier-General Gordon's force, intended to operate between Thall and the Shutargardan Pass. Deputy Surgeon-General H. B. Hassard was nominated Principal Medical Officer of the Khyber Division, the base hospital of which was to be formed at Peshawur to receive the sick of corps and batteries passing through to the front, as well as patients evacuated from the movable field hospitals. Rest depôts were to be formed at Jumrood, Ali Musjid, Basawul, Dakka, Bainkat, Safed Sung, and at any other post along the line of communications deemed necessary by the military and medical authorities. These were available for native as well as European troops, and a medical officer of either the Royal or Indian Service will invariably be posted there, with special instructions as to forwarding sick to the base, and returning the transport to the front, great stress being placed on this latter point. At each base an officers' hospital was opened, and a small hospital for officers was also to accompany every section of the field hospital. At Lundi Kotal, Jellalabad, and Gundamak field hospitals (stationary) were established.

Kandahar remained the base of the division under Major-General Sir Donald Stewart, Deputy Surgeon-General A. Smith being the Principal Medical Officer. Kelat-i-Ghilizie, and probably Ghazni, if the column advanced as far, would be utilised for depôts and stationary hospitals, convoys of sick and convalescents returning to India *vid* Quettah from time to time. The experience gained in the Afghan war will be advantageous in completing and perfecting various minor points of detail in equipment, and the general organisation of the field hospitals.

SMOKING IN THE DARK.

THE question has been asked why a man smoking a pipe should not be aware when the candle is put out whether the tobacco is still burning. There is, first, the point of fact. It may be questioned if anyone really finds himself in the difficulty supposed. We believe, under certain conditions, the doubt may exist. Smokers are not always large consumers of the weed. They often form a habit of taking very little smoke into the mouth, and of breathing chiefly through the nose. The consequence is that the "pleasure" of smoking *may* consist in having something to do, and the sensation of doing that something is quite as likely to be a matter of seeing as of tasting. In cases of this class the smoker, being deprived of his accustomed evidence or means of enjoyment, may be distressed. Of course, it is not alleged that a man cannot ascertain whether the contents of his pipe are lighted when he happens to be in the dark. That would be sheer folly. Meanwhile the experiment, if such it can be called, is well calculated to draw attention to the economic question how far the pleasure of smoking is generally imaginary. If it be, a suitable substitute for the expensive cigar and wasteful pipe might be found in some permanent material, of proper consistency, moulded into the approved shape. It has long been a mystery to some smokers how other smokers could systematically smoke bad cigars; the mystery may be dispelled if it should turn out that the fumes of the tobacco consumed are not even inhaled!

JOHN GIBSON FLEMING.

WE cannot be content with the obituary notice from a friendly hand, which we publish elsewhere to-day, of Dr. John Gibson Fleming, though it well describes the manner of his life and character, and the loss which has befallen Glasgow by his death. Dr. Fleming was eminently a Glasgow man, and enthusiastic in anything which interested Glasgow, socially, politically, and especially medically. But he was far more than a Glasgow man. For fifteen years he represented the Faculty of Physicians and Surgeons in the General Medical Council, and it is not too much to say that the General Council listened to none of its members with more respect than to Dr. Fleming, and that the intimation of his retirement was received with great regret by his colleagues, and all who had been accustomed to meet him in London. The qualities which endeared Dr. Fleming to his very large circle of friends were his strong common sense

his thorough downright honesty, and his genial and hospitable nature. Dr. Fleming was for many years intimately associated with this journal, and we were indebted to him down to a very late period for very valuable communications. Dr. Fleming was an excellent surgeon. He was a candidate in 1860 for the Regius Professorship of Surgery in the University of Glasgow. He did not succeed, but he was only beaten by Professor Lister, and we have good authority for saying that if the appointment had rested with any Glasgow authority Fleming would, in all probability, have been selected. Dr. Fleming's intimate friends knew that his health had been somewhat below par for a few years, but his life was prematurely lost, as so many valuable lives are still lost, with all our boasted sanitary laws, by typhoid fever, clearly declared and diagnosed. In early life he nearly fell a victim to typhus. It is satisfactory to know that Dr. Fleming's name, and, let us hope, much of his good influence, will be continued in the profession.

THE EGLINTON LUNATIC ASYLUM, CORK.

THE *Irish Daily News* reports that the resident physician of the Eglinton Lunatic Asylum, near Cork, Dr. Eames, has recently had to reply to a series of charges to which he has been subjected by the Management, and which appear to be of the most curious description. With one exception, our contemporary characterises the charges as "trumpery." They related to the position of the cricket-ground and the use of part of it, the application of a part for lawn tennis; the use of the market-cart by Dr. Eames to take himself to town; the boiling of pork to enable parsnips to be consumed by the patients, and other trivialities of a similar sort. The one charge which had even a semblance of importance was that Dr. Eames had departed from a general rule which requires him to obtain the sanction of the Board before ordering additions to, or alterations in, the structure of the asylum, but this charge was conclusively shown to have no real foundation, and Dr. Eames had to be honourably acquitted on all the charges. The curious proceedings of the Management in this matter have been the occasion of eliciting from parties of all shades of opinion the warmest expressions of approval of his conduct since he had become the superintendent of the asylum. Under his care it would seem that the state of the asylum and of the patients has wonderfully improved in every respect, and that this has been effected judiciously and even thriftily. It does not appear in what fashion a previous unbounded confidence of the Management in Dr. Eames became disturbed, but the disturbance seems to have resulted solely in a confirmation of the high opinion which is generally entertained of his official services, and his high professional and personal reputation.

COLLOID DEGENERATION OF THE SKIN.

A CASE of this rare skin disease is reported by M. Ernest Besnier in the last number of the *Gazette Hebdomadaire*. The patient, a man aged forty-six, entered the St. Louis Hospital in July, 1879, for extensive pityriasis. It was then noticed that the upper part of his face was the seat of a peculiar eruption having the appearance of "citrine" vesicles. These varied in size, from a bright-yellow spot only visible with the aid of a lens, to a mass as large as a grain of corn. Upon pressure and puncture it was found that the eruption was vesicular only in appearance, and upon scraping the skin a colloid substance came away in the curette. Similar deposits of this gelatinous matter were seen on the inner side of each cornea, and one patch existed on the septum, in the left nostril. Locally the eruption did not seem to have caused any trouble, at any rate not before the patient's attention was called to it. The general health was satisfactory; urine normal; the liver and spleen were healthy; the appetite and digestion good, although the patient sometimes suffered from colic and pneumatosis. The only complaint made was of occipital headache, which occurred daily. Microscopical examination of a portion of the skin showed that the lesion consisted of a colloid degeneration of its connective tissue. M. Besnier thinks that this case is analogous to one related by E. Wagner in the *Archiv der Heilkunde* for 1866, and improperly described as "colloid-milium."

THE SANITARY RESPONSIBILITIES OF THE CORPORATION OF LONDON.

THE possession of a property valued at two and a half millions sterling has its responsibilities, and we may assume that the Corporation class their foreign cattle market at Deptford as something of the "white elephant" variety. Some months ago Mr. Pink, officer of health for Greenwich, commenced a campaign against them by request of his district board of works. But the work done, it appears, was not sufficient, for those nearest to the market, Messrs. John Penn and Son, have been complaining again, and again Mr. Pink has presented a very practical and common-sense report, in which the evils resulting from a badly-organised and inefficiently administered slaughtering, bone-boiling, tripe-boiling, and fat-collecting establishment are fully and categorically set forth. As this yard is now one of the largest of its kind in the United Kingdom, we cannot congratulate those whose ill-luck it is to carry on their business there, for it seems tolerably clear that those entrusted with the work entered on it without a sufficient knowledge of the details, simple as they may be. It was decided at the board on Wednesday, the 8th inst., that, if the recommendations urged in Mr. Pink's letter were not carried out, summonses would be issued against the Corporation.

HYDROPHOBIA.

DEATHS from hydrophobia have been reported during the past week from Sheffield and from Leeds. From an account of the former which has appeared in the *Sheffield Daily Telegraph*, it appears that the sufferer was a man, forty-four years of age, who was bitten on the 18th of September by his own dog, a Skye terrier. The animal, which on the preceding day had been "tumbling about" in an unusual manner, howled loudly in the night, and the man got up and thrashed it, receiving a bite on the thumb. The wound bled freely; he applied laudanum and bound it up. On the following morning the dog was drowned on account of its peculiar behaviour. In the course of a few days the wound healed. On October 4th the bitten man began to feel some stiffness in the arm, and this on the 7th became much more intense, and on the 8th he was found by a medical man, Dr. Morton, of Brightside, suffering from irritability, difficulty in swallowing, and other symptoms which were recognised at once as due to hydrophobia. Maniacal symptoms set in early the next morning (the 9th), and attempts at swallowing excited convulsions. He died the same afternoon. Another resident in the house had observed the peculiar behaviour of the dog, and it appears that it had had several fights with other animals. The case and the coroner's remarkable observations at the inquest illustrate the urgent need for diffusing a knowledge of the early symptoms of rabies. Had they been known, the cause of the animal's conduct would have been suspected, and the man's life saved. The coroner appeared to imagine that a rabid dog will not allow itself to be fondled, and invariably tries to bite. It ought to be generally known that this is not always the case. Rabid pets occasionally show no tendency to bite, and have even in some instances been nursed throughout their illness by

their owners and died in their arms. How many more lives are to be sacrificed to this terrible disease before Government takes some measures to diffuse a knowledge of the early symptoms of rabies? If a handbill description of them were to be put up at every post-office and police-station in the kingdom, and, still better, at every public-house, there cannot be a doubt that many frightful deaths would be prevented every year. The responsibility for the deaths which might thus be averted lies at the door of the Government which neglects this simple measure.

INFECTED HORSE-BOXES.

THERE is, we believe, a statute which, by some more or less complicated process, can be brought to bear on the keepers of commission stables and those devoted to the accommodation of omnibus- and cab-horses, to secure at least a show of cleanliness. Is there any forgotten Act which could be discovered and applied to the discomfiture of railway authorities who do not trouble to cleanse the horse-boxes in which they convey a succession of animals in divers conditions of health and disease and thereby disseminate the affections to which horseflesh is heir, with perfect impunity? Even if there be no care for the health of horses on any other score than that of the injury disease entails on property, it would be desirable to compel the cleansing of railway horse-boxes. It is surprising that a matter of this nature should require to be noticed publicly before the obvious precautions suggested by experience are taken. The energy of inaction is growing stronger each year, and will soon come to be the dominant force in society. Then no one will do anything except under compulsion, and it will be understood that every reform, however simple in itself, must be commenced with a kick.

THE CANAL BOATS ACT.

MR. GEORGE SMITH, of Coalville, the enthusiastic supporter of the Act, writes to *The Times* to say that these craft are, to a great extent, registered in the provinces, but that the provisions of the measure are ignored in London and its environs. He seems to forget that though a great number of these so-called "monkey barges" may be daily seen on the river both off Brentford and Limehouse, where they enter and leave the Thames, as well in many parts between these places, the Local Government Board does not see fit to make the Port Sanitary Authority a registration authority; so that, although the officers of the Port Sanitary Committee could "catch" the majority of the Grand Junction or Regent's Canal craft at one time or other, the practical step of making them active agents in carrying out the Act, weak as its provisions are, does not seem to have been thought of. We suspect that the Select Committee and the Local Government Board, when the Bill was being framed, trusted too much to Mr. Smith, of Coalville, and too little to several other practical individuals, whose advice might, as we believe, have been sought with considerable advantage.

LEPROSY IN BRITISH GUIANA.

A PAPER has been printed by the Government of British Guiana, containing certain notes on cases of leprosy at the Leper Asylum, Mahaica, in that colony, by Mr. John D. Hillis, F.R.C.S., the medical officer of the asylum. The notes refer to 188 cases of Elephantiasis Græcorum, admitted to the hospital, and of which, with the exception of eighteen, the histories are stated to have been fairly complete. Of these cases, 103 were anæsthetic, 34 tubercular, and 51 mixed; and the ages of the patients ranged from four years to eighty-six. In 31 cases a history of hereditary tendency was made out, direct in 17, collateral in 14. Referring to the localities from which the patients came, Mr. Hillis notes that the cases which occurred in, or formed, groups greatly outnumbered the single ones, and he is of opinion that a study of the particular localities will not afford a clue to the reason why one place furnished more cases than another. The greatest number came from the district of Mahaica, where a large leper asylum has been long established, the inmates of which have been allowed to mingle with the surrounding inhabitants. Much importance is assigned to this fact, and Mr. Hillis thinks that there is evidence of a number of the cases he records having arisen from contagion. Ninety-two cases (67·17 per cent.), in fact, are specified "in which contact, more or less prolonged, of the unhealthy with the healthy is given as the most probable factor in the propagation of leprosy." In making use of the word "contagion" in connexion with the disease of Elephantiasis Græcorum, Mr. Hillis observes: "I am fully aware of all the difficulties and the hostile criticism that a writer on such a subject must expect to meet in view of the authoritative decision thereon already given by so high an authority as the Royal College of Physicians. Nevertheless, a fair study of the disease, carried on for some time in the place where a thorough knowledge of the subject is most likely to be obtained, has so convinced me that I am constrained to make known my views and convictions."

EGGS NOT FOOD.

IF eggs are not food, within the meaning of the statute, the sooner the law is altered the better will it be for public safety and the credit of common-sense. As well might it be declared that flour is not food because it may be used for making paste or employed as an article of the toilet, as that eggs are not to be included in the category of articles which it is necessary to protect from adulteration or impurity, because their primary function may be to produce chickens. It is the mission of the calf, known to butchers, to develop into an ox and be slain and sold as beef, but that circumstance does not suffice to eliminate veal from the list of meats which must be supplied in a fresh and pure state, if supplied at all. These hair-splitting discriminations may be very edifying to the lawyers, but they mean mischief to the public. It is time common-sense began to sway the decision of courts of all grades in matters affecting the health of the community. Not long ago it was ruled that the Adulteration Act could not be worked as it was clearly intended to be worked, because the inspector who laid himself out to detect a fraud could not be damaged by the purchase of an adulterated commodity. This monstrous piece of false logic was exposed. It remains to show the impolicy of a recent decision at Leeds. Surely judicial casuistry and example must be catching, and the stipendiary at Leeds has taken the infection.

"SCHOOL-OFFICES."

THE Educational Department of the Privy Council Office has at last issued, for the guidance of school-managers and others whom it may concern, a memorandum of practical suggestions as to the construction and cleansing of school-offices—in other words, on the means of excrement disposal and school premises. The suggestions have been prepared by the Local Government Board, and they are in every respect most admirable. They set forth those points in the construction and management of the school-offices which are requisite for the avoidance and prevention of that state of excremental nuisance which is too common in school-premises, and this not only with regard to nuisance, but with regard to the future habits of the children in respect to excrement-disposal. The suggestions rightly take the point of view that, unless the child be trained to better habits when young, it is idle to hope for their acquisition, at least in a large number, in after-life. Education in good privy-habits and associations is as necessary as in any other

form of good habit. This memorandum on "School-Offices" is published by Knight and Co.; but we regret to observe that, while the document refers to the celebrated report of the Local Government Board on Means of Excrement Disposal for detailed information on the subject, it does not state where copies of this report can be most readily procured.

THE IRISH MEDICAL ASSOCIATION AND VACCINATION.

AT a quarterly meeting of the Council of the Irish Medical Association, held at the Royal College of Surgeons on Tuesday, the 30th September, a resolution was passed acknowledging the able and valuable services of Mr. Charles H. Meldon, M.P., in promoting the Vaccination Amendment (Ireland) Act, 1879, the provisions of which must prove very beneficial to the Irish public. At the same time the Council expressed their decided opinion that until the provisions of the law in force in England are fully extended to Ireland, it is futile to suppose that equally satisfactory results as regards protection of the Irish public from small-pox, or mitigation of that disease and its dread consequences can possibly be realised. The Council therefore earnestly urged Mr. Meldon to continue his exertions in endeavouring to obtain for Ireland, in respect to vaccination, legislation as complete as that which exists in England.

ENTRIES AT THE MEDICAL SCHOOLS.

WE have received returns of the new entries at several of the medical schools. At present the list is incomplete: St. Bartholomew's, 156; London Hospital, 106; University College, 91, exclusive of 39 entered for the Preliminary Scientific Examination; Middlesex, 56, including 13 for Dental diploma only; Charing-cross, 38; Westminster, 31, including 8 "partial entries"; St. George's, 51, including 5 "partials"; St. Thomas's, 87, including 41 "partials"; King's College, 59; Guy's, 115, including 12 for special courses. Durham, 24, and 27 others entered for the degree only; Leeds, 41; Bristol, 18.

NAUTICAL NOTES.

THE *Army and Navy Gazette* reports Dr. W. T. Domville, C.B., R.N., as suffering from a mild form of enteric fever, but still holding on at his appointment at Haslar, of which he is inspector-general.

Fleet Surgeon Longfield, R.N., of H.M.S. *Tenedos*, having been dangerously wounded at Isandula, was sent home and arrived from the Cape on the 6th inst., in H.M.S. *Juno*. But it is said that the wounds are now progressing favourably.

A VIGOROUS opposition is being shown by the ratepayers of Liverpool against the proposition of the Town Council to obtain a water-supply for the town from the Vyrnwy Valley. On the 9th inst., at a town's meeting held to consider the question, the proceedings are reported to have been extremely animated, and ultimately the scheme promoted by the Corporation was condemned by a large majority. A poll, however, was demanded, and will be taken as soon as arrangements can be made.

WE regret to learn that Dr. Leared, who returned from his summer holiday seriously indisposed, is still very ill, and that his condition is such as to cause considerable anxiety to Dr. Bristowe, who is attending him.

SURGEON-GENERAL THOMAS CRAWFORD has been ordered to proceed to Madras, to relieve Surgeon-General C. A. Gordon, C.B., as principal medical officer of the Madras Presidency.

AT the meeting of the Pathological Society on Tuesday next the new system will be inaugurated of the exhibition of specimens, drawings, &c., unaccompanied by oral communications. This will take place in addition to the ordinary business of the Society, which will be carried on as heretofore. All specimens &c. to be exhibited in this manner must be on the table by 8 o'clock, the chair being taken, as usual, at 8.30 P.M.

SURGEON-MAJOR EDWARD LAWRIE, Bengal Medical Service, has been appointed to succeed the late Dr. Neil as Professor of Surgery in the Lahore Medical College.

REPORT
OF
The Lancet Special Commission
ON THE
SANITARY CONDITION OF THE ITALIAN QUARTER.

FROM time to time, and notably during the dull season, energetic protests are made against the worrying sound of the street organs; or some one spreads alarm concerning the nature of penny ices, while others are ready to rush into print with painful stories of cruelty and tyranny practised towards little Italian boys who are sent out to beg while playing the hurdy-gurdy or some equally objectionable instrument. In spite, however, of these recurrent complaints the Italian colony has increased yearly, and with it nuisances far more serious in character than those which have attracted so much public attention. After all, it may be urged that the organs, especially the piano-organs, have helped considerably to spread some knowledge and taste for good music among the poorer classes whose opportunities of hearing any sort of music are very limited. The penny ices we carefully analysed on a previous occasion, and found them free from poisonous colouring matter; while the plump cheeks and bright smiles of the Italian boys we meet in the streets may lead us to infer that the cases of cruelty are at least somewhat exaggerated. But the establishment of this colony in our midst has nevertheless given rise to a grievance on which we cannot lay too much stress. These Italians form a separate class, live in a special district, and come, for the most part, from the least civilised provinces of Italy, notably the Calabrian mountains, Sicily, and the neighbourhood of Naples. They bring with them their native antipathy to soap-and-water; they continue in their total ignorance of the most elementary sanitary principles. It is from these people that the renowned south Italian brigands are recruited; but, in England, they soon learn that dishonesty or violence of the desperado type does not pay. Why have they not acquired a similar respect for our sanitary laws, and how is it they contrive to evade that to which the English poor have to submit? The fact that they are foreigners is not sufficient excuse for allowing them to live in a condition likely to originate and spread an epidemic. Such is the tenacity with which they adhere to their innate love for overcrowding, foul air, and dirt, that they will endure any amount of fatigue so as to live together, and away from English influence and interference. Hence, though one may drag his organ daily to Peckham-rye, and another sell his ices at Victoria-park, yet they will return in the evening to Saffron-hill, and huddle together with their fellow-countrymen, rather than live near their "beats," and be compelled to mingle with the English. Under such circumstances it was evident that unless the

law was enforced with exceptional energy, this Italian colony would soon become a standing menace to the public health of London; and our investigations have confirmed in a lamentable and startling manner this anticipation.

We proceeded at once to Saffron-hill. Indeed it was not necessary to travel far. The colony is very compact, and where the Italian lives English rarely reside. Thus Eyre-street-hill presents the strangest aspect; and on a Sunday, when most of the Italians are at home, it is difficult to believe that this is a street in London. Fleet-court, which enters this thoroughfare, is exclusively inhabited by Italians. Not a word of English is spoken there from year's end to year's end. And, further to add to the foreign aspect of the place, the Italians, on fine, dry summer evenings, come out of the wretched houses and sleep on the smooth flagstones of the court, just as they may be seen sleeping on the church steps in Italy. On these occasions the court is so crowded with prostrate Italians that it is impossible to walk down. But a glance at the interior of the houses would suffice to show why the open street on a fine evening is preferable and far healthier.

Our first visit was paid to the house of a celebrated padrone in Laystall-street. We passed through a little shop, where all manner of Italian goods are sold, from the hard cheese made with horses' milk to the delicate Mortadella and Bologna sausage. This Italian tradesman had the good fortune to secure an English wife. His rooms were tolerably clean, but he had sublet the house at the back to the padrone whom we were about to visit, and also the basement, which was formed into a sort of kitchen, with shelves along the walls where the barrel-organs might be deposited, a long table for the rolling out of maccaroni, a fierce coke fire and huge saucepans for the cooking of the common fare. Here, in this dark, ill-ventilated, underground place, which is more like a cellar than a basement, the Italian organ-grinders congregate, to rest, eat, play cards or *mora*, smoke, talk, and squabble. The floor, ceilings, and walls were black with smoke and dirt. The heat and stench in this common room, when filled with inmates, must be intense, and the chance of fire not slight. It was said, however, that no one slept here; but we would not answer for what occurs in an emergency, when other parts of the house are full. In the back yard above is a small washhouse, ventilated only by a little window measuring two feet by three; and here is stored, together with accumulations of foul linen and other dirt, the flour for making the maccaroni.

We now entered the house sublet to the padrone where he locates the organ-grinders whom he has imported from Italy, and to whom he lends the organs. The padrone is careful not to charge any rent for the sleeping accommodation he gives. This would convert the organ-grinders into lodgers, and compel him to come under the operation of the Common Lodging-houses Act. The Italians are taught therefore to deny the payment of rent, and to profess to be the padrone's servants. Indeed, a great portion of the present evil would at once be swept away if it were possible to compel every padrone to register himself as a common lodging-house keeper. As it is, the laws are set at open defiance. In this house dirt and overcrowding were the principal faults we could find. The inhabitants were all men who go out with the organs all day long, no one remaining at home to make the smallest pretence at cleaning the place. It was admitted to us that the floors had not even been swept for two years, much less scrubbed or washed. It was not possible to see through the window-panes for the dust that had accumulated upon them. As a proof of these allegations, we noted that the splashing of the whitewashing still remained on the window-pane, doors, &c., and we ascertained that the house had not been whitewashed for two years. The rooms contained as many double beds as could be got into them, and no other furniture whatsoever, unless we consider an occasional trunk or a barrel-organ as such. There were no washing-stands, no basins, no towels,—nothing but beds with very scanty, filthy black bedding, swarming with vermin. Should one of the organ-grinders be inspired with the rare desire to wash himself, he would have to proceed to the tap in the yard and dry himself on his own clothes. Two, if not three, men sleep in each bed, though at first they are quite strangers to each other. The principal room in this house, including the area of the staircase leading to it, measured about 1550 cubic feet. We included the staircase, which was equal to about 320 feet cube, in our measurement, as we were assured that men sometimes slept on the steps or landing, and that this small area would occasionally shelter as many as twenty persons for the night, giving to each therefore from 70 to 80 cubic feet of air! This house, we should add in conclusion, is so filthy, so overcrowded, that even in this wretched neighbourhood it has acquired a bad name, and the English and Irish costermongers express their contempt for it by throwing their vegetable garbage at its walls, windows, and on to its roof. On one occasion no less than twenty cabbage stumps were removed from the roof.

We next visited another padrone in Eyre-street-hill, who does business on a very large scale, and possesses no less than three houses, for which he pays two guineas a week rent. His largest house was pointed out to us as one of the worst in the street. A neighbour declared that it must have contained at times as many as fifty persons, men, women, children, and a few of the English servant girls who have been persuaded to live with the Italians. The scenes enacted in this place were the subjects of many complaints addressed to us, coupled with inquiries as to the possibility of police interference. In spite, however, of the desperate character given to this house, we must with pleasure record that we were received by its inhabitants with the utmost courtesy, and if our questions were answered with some hesitation, we were in any case allowed to see over every part of the premises. The front basement, a dark damp room, with the crumbling ceiling on a level with the street, and threatening to fall in at any moment, was inhabited by an English woman, formerly a domestic servant, now the wife of an Italian marble-cutter. Her husband was not, however, above selling penny ices on the Sunday, while the woman had often been out with a piano organ. Their room was totally unfit for habitation, and rendered much worse by the back basement. This was a sort of washhouse, where the tub receiving the water-supply leaked so as to convert the floor into a veritable quagmire, the slush being a mixture of mud, with the rotting refuse of the eggs used for ices, soapsuds from the washing of linen, vegetable and household refuse. As each flag-stone tilted up when trod upon, it emitted from underneath effluvia which accentuated the surrounding bad odours. The ground-floor front was a small overcrowded bedroom, the back a day-room, where a number of Italians were loudly discussing a game of cards. The first-floor front we examined with some care, for this is the room where the padrone himself slept; and as he is a man of means, we expected to find some sort of decency and comfort. Yet this chamber contained three double beds. In the first slept a woman and her child; in the second the padrone himself slept, we were assured, alone; while in the third bed, situated in the inner or back recess of the room, there were a man and his wife! Thus three separate families slept in the one room, and this including the householder himself, who might have had better knowledge of our laws. This room, we calculated, contained barely more than a thousand cubic feet of space. The back room on the same floor measured 1060 cubic feet; and here, again, in one bed slept a man and his wife, in another bed a woman and her child, while a young woman slept in the third bed. The top front room has sleeping accommodation for seven persons; while at the back, the roof slanting off gives space only for a little lumber-room, but even there a bed has been introduced. Altogether, the landlord professed to accommodate twenty-seven persons, and freely admitted the mixing of sexes in one room—unmarried girls sleeping in one bed, a married couple in another, and a woman and a child in the third bed, &c. Every room containing 1000 cubic feet of air had three double beds in it, and perhaps a crib for one or two children as well; nor did these persons, who lived indiscriminately together, profess to be related to one another. Thus the laws of health and of decency were trampled under foot, and no attempt was made to disguise the fact. We believe, however, that the condition of this house during a prosperous busy season is infinitely worse than what we saw and have described. The cold wet summer has proved most disastrous in its effects on the penny-ice trade, and an enormous number of Italians have returned to their native country to await a more propitious season; otherwise the overcrowding would be much greater even than we witnessed.

The two other houses belonging to the same landlord are smaller, and stand at the corner of Somers-street. Here we found a room which, as the ceiling was nine feet high, contained about 1800 cubic feet of space, though otherwise it was not much larger than the other rooms we visited, and

which were only a little more than six feet high. This room had but one window, which would not open at the top, and yet it contained four beds. In the first there was a man and his wife; in the second another man and his wife; the third held a young unmarried woman; while in the fourth bed there were two English girls, formerly domestic servants, and aged respectively seventeen and sixteen years. These English girls were in the habit of going out dressed as Italians with piano-organs, and though they complained that their receipts had of late greatly fallen off, they did not seem in any way dissatisfied with their present mode of life. The house next door had also four beds in the first-floor room; two women slept in two of the beds, and two married couples in the other two beds. The ceiling was falling in. The room above was inhabited by the only large Italian family we have seen—a man, his wife, and seven children. The condition of this room was most unwholesome. The roof, slanting off, was, on one side, only five feet from the floor; the wet came through and saturated the bedding, and the mattress and bedsteads were here and there covered with mould due to the damp. Roughly estimated, the room would contain 1400 cubic feet, giving about 150, or, in any case, less than 200 cubic feet per person. Further, the sanitary contrivances of these two houses are most defective. The one has no closet, the other no water-supply; and, as it is necessary to bring the water in from one house to flush the closet in the other, the latter is naturally neglected and constantly stopped up. Nor are these houses provided with dustbins; and the result is that all the refuse is thrown under the staircase, where it rots and throws off gases that pervade the whole dwelling.

In the face of all these facts it will be natural to inquire how it happens that the death-rate is not higher and epidemics are not more frequent in such a quarter. The apparent lowness of the death-rate may at once be explained by the scarcity of children. Full-grown strong men are required to drag the ice-cart or organ about London, and these men have already encountered greater dangers of epidemic in their own country. Then the better part of their time is spent in the open air, away from the unwholesome influence of their lodgings. They are also an abstemious, frugal race. Now, however, a great number are bringing their wives and women over with them. Small families are not so rare as they used to be in the Italian colony, and the dangers for the future are therefore likely to be much greater than they were in the past. At the same time, though the prevalence of zymotic disease is not so general as might be anticipated if the overcrowding and bad sanitation alone are taken into consideration, the district is far from healthy. We know one house in Eyre-street-hill where there have been three cases of small-pox, another in Eyre-court where fever has prevailed, and there is at present an epidemic of measles throughout the neighbourhood. When a case of serious illness occurs the Italian generally sends for a local practitioner, who, as a rule, only sees him once, as he will not give more than the modest fee of half-a-crown, which includes medicine. If the patient recovers the doctor never hears of him again; if he dies his friends come to the practitioner for a death-certificate. The complaint is rarely reported to the sanitary authorities, though often infectious. So great is the ignorance of the dangers of infection that the friends will often kiss a small-pox patient. In Somers-court we came in contact with some cases illustrating this carelessness. Here the drains were so constantly stopped that they overflowed, and the inhabitants had to place planks on stones so as to step from house to house without treading in the sewage matter lying exposed in the open court. In one of the houses where the measles had attacked several persons, we found in one room, measuring about a thousand cubic feet, a man and wife, a grown-up son, the wife's father, and two young children, all sleeping together. In the daytime a third child lived in this room. Both day and night there is someone in the room, and, when we called, the inhabitants had just been making some maccaroni. The paste, still moist, was stretched out to dry over the most repulsive and disgusting bedding; the atmosphere was fetid, the room dark, everything around dirty. Those who did not suffer from measles suffered from rheumatism, while the man living on the ground floor complained of frequent morning headaches and inability to eat his breakfast—a natural result of the foul air breathed during his sleep. Finally, we entered another house in the same court, where we were told there was a case of small-pox. Here there were four rooms on the first floor. The man who was supposed to be suffering from small-pox, but who in reality had only an attack of measles, had been living in a room with some women and children, and lay ill there for some time, so that the place was thoroughly infected. In the second room there was already a child ill with measles, making two cases on the same floor. So slight is the knowledge of the laws of infection, that the people imagined that by removing the man to the third room, where single men alone sleep, the women and children living in the already contaminated room would escape any evil consequences. But, not contented with thus infecting three rooms, they called the man out of the fourth room to nurse the patient, at the same time shutting the windows hermetically, but often opening the doors, so that the foul air travelled freely from one to the other. We should also observe that in the room below there was a child just recovering from measles, and that the closet used by this household was blocked up, and emitted the foulest odours. No one, however, had interfered to put an end to this dangerous state of affairs. The drains, it is true, are occasionally looked at and repaired by the sanitary authorities, while disinfectants are also sprinkled outside the houses; but the overcrowding and the disgraceful intermixing of the sexes continue unchecked. Many cases of infectious disease escape notice, dirt and vermin are not removed, closet accommodation is often altogether inadequate, the houses are in a ruinous crumbling condition, people are allowed to sleep underground, or under roofs that do not exclude the rain. A local practitioner assured us that on one occasion he had to open his umbrella while going upstairs to visit an Italian. Finally, the milk, the eggs, the cornflour mixtures, &c., used to make the penny ices, are left standing in the foulest dens, where they must absorb the noxious gases that infect the atmosphere, and where they are boiled and mixed in the same saucepans and cauldrons in which the Italians scald and wash their dirty linen! It is to be hoped that the freezing process may kill the germs of disease which must thus be occasionally present in the milk used for the ices, but the idea is not appetising, and the prospect somewhat uncertain; in short, the entire moral, social, and sanitary condition of this Italian colony calls for immediate reform.

THE CLIMATE OF AFGHANISTAN.

SINCE it is not improbable that we shall be forced into a more intimate acquaintance with Afghanistan than hitherto has been the case, the following notes on the climate of that country, taken from an article in the *Encyclopædia Britannica*, by Colonel Yale, C.B., may prove of interest to the readers of THE LANCET.

"The variety of climate is immense, as might be expected. At Kabul and over all the northern part of the country to the descent at Gandamak winter is rigorous, and especially so on the high Aracosian plateau. In Kabul the snow lies for two or three months; the people seldom leave their houses, and keep close to stoves. At Ghazni the snow has been known to lie long beyond the vernal equinox; the thermometer sinks to 10° and 15° Fahrenheit below zero; and tradition relates the entire destruction of the population of Ghazni by snow-storms more than once.

"At Jalalabad the winter and the climate generally assume an Indian character, and the hot weather sometimes brings the fatal *simúm*. The summer heat is great everywhere in Afghanistan, but most of all in the district bordering on the Indus, especially Sewi on the lower Helmand, and in Seistan. All over Kandahar province the summer heat is intense, and the *simúm* is not unknown. The hot season throughout the 'Khorasan' part of the country is rendered more trying by frequent dust-storms and fiery winds; whilst the bare rocky ridges that traverse the country, absorbing heat by day and radiating it by night, render the summer nights most oppressive.

"At Girishk, Ferrier records the thermometer in August to have reached 118° to 120° Fahr. in the shade. At Kabul the summer sun has much of its Indian power, though the heat is tempered occasionally by breezes from Hindu Kush, and the nights are usually cool. Baber says that even in summer one could not sleep at Kabul without a sheepskin, but this seems exaggerated. At Kandahar snow seldom

falls on the plains or lower hills; when it does it melts at once.

"At Herat, though 800 feet lower than Kandahar, the summer climate appears to be more temperate, and in fact the climate altogether is one of the most agreeable in Asia. In July, Ferrier says, he found the heat never to pass 98°, and rarely 91° to 93° F. These are not low figures, but must be compared with his figures at Girishk, just given. From May to September the wind blows from the N.W. with great violence, and this extends across the country to Kandahar. The winter is tolerably mild; snow melts as it falls, and even on the mountains does not lie long. Three years out of four, at Herat, it does not freeze hard enough for the people to store ice; yet it was not very far from Herat, and could not have been at a greatly higher level (at Kafir Kala, near Kassan), that in 1750 Ahmed Shah's army is said to have lost 18,000 men from cold alone in a single night. ..... Speaking generally, the climate of Afghanistan is a dry one. The sun shines with splendour for three-fourths of the year, and the nights are even more beautiful than the days. Marked characteristics are the great differences of summer and winter temperature and of day and night temperature, as well as the extent to which change of climate can be attained by slight change of place. As Baber again says of Kabul, at one day's journey from it you may find a place where snow never falls, and at two hours' journey a place where snow almost never melts.

"The Afghans vaunt the salubrity and charm of some local climates, as of the Tobah hills above the Kakar country, and of some of the high valleys of the Safed Koh. The people have by no means that immunity from disease which the bright dry character of the climate and the fine physical aspect of a large proportion of them would lead us to expect. Intermittent and remittent fevers are very prevalent, bowel complaints are common, and often fatal in the autumn. The universal custom of sleeping on the house-top in summer promotes rheumatic and neuralgic affections; and in the Koh Daman of Kabul, which the natives regard as having the finest of climates, the mortality from fever and bowel complaints between July and October is great, the immoderate use of fruit predisposing to such ailments. Stone is frequent, eye disease is very common, as are hæmorrhoidal affections and syphilitic diseases in repulsive forms. A peculiar skin disease of syphilitic origin prevails at Kandahar, and native physicians there are said by Bellew to admit that hardly one person in twenty is free from the taint in some form."

HEALTH OF LARGE ENGLISH TOWNS.

FORTY-FIRST WEEK OF 1879.

PUBLIC health, judged by the Registrar-General's urban statistics, continues in an unusually satisfactory condition. In twenty of the largest English towns, containing nearly a third of the entire population of England and Wales, 5399 births and 2771 deaths were registered in the week ending last Saturday. The births exceeded by 217, while the deaths were so many as 599 below the average weekly numbers during 1878. The deaths were 47 below the number returned in the previous week. The annual rate of mortality in the twenty towns, which had been equal to 18·8 and 19·9 in the two preceding weeks, declined again last week to 19·6. During the thirteen weeks of last quarter, ending 27th ult., the death-rate in the twenty towns averaged only 18·3 per 1000, against 23·1, 20·6, and 23·8 in the corresponding periods of the three years 1876-7-8; this is the lowest summer death-rate in those towns on record. The lowest death-rates in the several towns last week were 13·7 in Bristol, 14·6 in Wolverhampton, 15·4 in Leicester, 16·2 in Portsmouth, and 16·4 in Birmingham. The rates ranged upwards in the other towns to 21·9 in Sunderland, 23·5 in Salford, 24·1 in Manchester, and 24·5 in Liverpool; the high rate in each of these four towns, except Manchester, was mainly due to excessive zymotic fatality. The deaths referred to the seven principal zymotic diseases in the twenty towns further declined last week to 474, from 537 and 490 in the two preceding weeks; 151 resulted from scarlet fever, 149 from diarrhœa, 62 from measles, and 52 from whooping-cough. The annual death-rate from these seven diseases averaged 3·3 per 1000 in the twenty towns, and ranged from 0·7 and 1·2 in Wolverhampton and Norwich to 5·0 in Sunderland, 5·3 in Salford, and 5·8 in Liverpool. The deaths from diarrhœa exceeded the average number in the corresponding week of recent years; they were exceptionally numerous in Salford. The fatal cases of scarlet fever in the twenty towns, which had risen from 94 to 146 in the four previous weeks, further rose to 151 last week; the disease showed the largest proportional fatality in Sunderland, Liverpool, and Sheffield. The death-rate from measles was also excessive in Liverpool. Diphtheria caused 17 deaths in London, whereas only 2 fatal cases were recorded in the nineteen large provincial towns. No death from small-pox was registered during the week in any of these twenty large towns. The number of small-pox patients in the Metropolitan Asylum hospitals had declined to 42 on Saturday last, from numbers decreasing steadily from 111 to 45 in the seven preceding weeks. The 41 deaths referred to fever in the twenty towns showed a decline of 27 from those returned in the previous week; these deaths were proportionally more numerous in London than in the provincial towns.

Correspondence.

"Audi alteram partem."

PLEURAL AND DIAPHRAGMATIC TENSION.

To the Editor of THE LANCET.

SIR,—In the very instructive Croonian Lectures lately delivered by Professor Stone, and published in THE LANCET, the lecturer, at page 465, relates a case of empyema, in which, when tapping was attempted, no fluid could be withdrawn, and, there being no aspirator at hand, the child died. Another case is also reported, where no fluid issued from the trocar until a tube three feet long was added, so as to form a descending column with a suction-power sufficient to form a most efficient aspirator. The publication of these cases attracted the attention of Mr. Le Gros Clark, who in 1872 communicated a paper to the Royal Society, explaining the cause of the arched tension of the diaphragm after death so long as there is no air admitted into the pleural cavities. The result of his experiments led him to form the following conclusions:—"(*a*) That the passive tension of the diaphragm is due to atmospheric pressure on its abdominal surface, which is not counterbalanced by a corresponding pressure on the opposite or thoracic surface until air is admitted into the pleura. (*b*) That the lungs retain their supplemental air by virtue of this tense condition of the diaphragm, the elasticity of the former being resisted by the tension of the latter. (*c*) That the contractility of the lungs, tending to the expulsion of the supplemental air, removes the atmospheric pressure from the upper surface of the diaphragm, and thus produces and maintains its arched form and tense condition. (*d*) That as soon as the pressure on the inner and outer surfaces of the lungs was equalised, by the admission of air into the pleura, their contractility forced out the supplemental air. (*e*) That the diaphragm was rendered flaccid by the admission of air into the pleuræ, independently of the collapse of the lungs.

"Thus there exists a constant antagonism between the atmospheric pressure on the interior of the lungs and their elastic and contractile properties, tending to the expulsion of the air they contain, and this expulsive power is limited by the resisting tension of the diaphragm.

"In the recognition of the above facts I think that the extremely tense condition of the diaphragm has not received the notice which its practical importance deserves . . . . Without giving due weight to this property of the diaphragm it would be impossible to account for the trifling interference that the sudden removal of large distensions, such as pregnancy, ovarian tumours, exercises over the mechanism of respiration; this is accounted for by the passive tension of the diaphragm, which alike resists encroachment from below, and refuses the solicitation to descend which the removal of the pressure would seem to offer . . . . So then the normal state of the diaphragm, when at rest, is that of arched tension; and this condition is due to the elasticity of the lungs resisting the atmospheric pressure on its thoracic surface."—pp. 416, 417.

It appears to me that the above offers a very imperfect explanation of the normal condition of the lungs and diaphragm, inasmuch as no allusion is made to the mechanical action of the pulmonary and thoracic (including the diaphragmatic) pleuræ. The lungs cannot collapse in their normal state, because the pulmonary pleuræ are unable to recede from the thoracic and diaphragmatic pleuræ, and the diaphragm cannot become lax for a similar reason, just on the principle that a piece of wet leather, pressed tightly on a heavy weight, can raise the latter from the ground.

In a case of congenital deficiency of the diaphragm, reported by Mr. H. St. C. Carruthers in THE LANCET, p. 503, where the child lived more than ten days, it was observed that, when first born, it breathed heavily, and so continued to do until death. A post-mortem examination revealed both lungs pushed upwards and backwards; the diaphragm was entirely wanting on the left side at the back, and the chest cavity was filled by a mass of intestines, stated to be the cause of the collapsed condition of the lungs; whereas, in fact, the collapse of the lungs was the cause of the position of the intestines.

I remain, Sir, yours truly,
RICHARD NEALE, M.D. Lond.

Boundary-road, South Hampstead, Oct. 1879.

THE TREATMENT OF DYSENTERY BY RECTAL INJECTIONS.

To the Editor of THE LANCET.

SIR,—In your issue of Oct. 14th Dr. Houghton expresses a wish that the treatment of dysentery by bismuth injections, as recommended by him, should undergo a trial in a tropical country. I have pleasure in offering a confirmatory experience of that gentleman's estimation of this remedy under the desired circumstance.

In the course of large public practice in India, I have constantly had recourse to the exhibition of the subnitrate of bismuth, in cases of dysentery, both by the mouth and rectum. Its use by the mouth is by no means novel, the *rationale* of its action being the mechanical covering of the inflamed and ulcerated mucous membrane by a non-irritating and protecting film. Remembering that in a large proportion of cases the dysenteric mischief is situated in the lower part of the colon and rectum, I have always regarded an attempt to effect local treatment a matter of importance. In such cases benefit ensues as a result of directly curative measures; but even when an incorrect diagnosis of the chief site has been made—the actual position being higher up,—the effort to soothe the mucous membrane of the rectum, and allay spasm of the sphincter ani, amply repays the attempt by tending to the production of the *sine quâ non* of rest for the diseased bowel and the patients generally. The attainment of this object is, I think, frequently much assisted by the action of bismuth used per rectum. Although I have given this remedy as an injection, simply suspended in mucilage in the case of children (or in adults where opium in some form was being administered by the mouth), my usual plan has been to combine forty grains with half a drachm of tincture of opium, and, if intolerance of ipecacuanha by the mouth was encountered, also adding two scruples of that drug. In whichever form it was prescribed, I generally directed the bowel to be washed out in as gentle a manner as possible with lukewarm water, the object being to simulate the soothing process of fomentation; to procure, for contact with the drugs, a clean surface; and, finally, to diminish the chance of loss of injection by overcoming beforehand the spasm produced on the first introduction of the tube. Meddling with the rectum in this manner may seem opposed to the object of rest by unnecessary manipulation creating spasm, but I am convinced no injurious effect is caused. Far from this being the case, careful cleansing proves of the greatest utility by removing mucous and irritating secretions which, by their presence, excite tenesmus, a result analogous to the cessation of pain which may be witnessed after removal of a plug of tenacious mucus from the os uteri in cases of chronic metritis. Indeed, hydropathic (!) treatment of dysentery is by no means to be despised; I have seen a severe case of the acute form effectually checked by the use of the warm bath, fomentations to the abdomen, and copious warm water injections per rectum, without the use of any medicine. Two ounces of fluid, as used by Dr. Houghton, seems a somewhat smaller amount than usually desirable. As I regard the action of bismuth as merely mechanical, I attempt to give it in larger proportion—four to five ounces,—so that the protecting film may be well scattered over the rectal mucous surface. This amount, if the precaution of cleansing the rectum is attended to, is, as a rule, fairly well retained.

I may also mention I have found the soothing influence of a bismuth and opium injection beneficial after the employment of injections of nitrate of silver. In all cases, however, treatment by this method has been undertaken, as with Dr. Houghton, as merely subsidiary to the use of ipecacuanha by the mouth, if practicable. In the treatment of endless cases of famine diarrhœa and dysentery encountered during the late wretched famine in Southern India, the use of bismuth in ten-grain or scruple doses, combined with compound ipecacuanha powder proved, after an honest trial of every feasible method, to be the most reliable treatment. Given at a time when it is calculated the intestine is fairly quit of food substances, this combination at once soothes the frail atrophied mucous membrane, and affords a film which protects its surface from the action of changed and irritating secretions.

Believe me to be, Sir, yours faithfully,
W. G. KING, M.B., Surgeon I.M.D.

Killcott, Godalming, October 8th, 1879.

STAPHYLORAPHY.

To the Editor of THE LANCET.

SIR,—Mr. Thomas Smith criticises my communication on Staphyloraphy, and refers me to a paper published by him in the St. Bartholomew's Hospital Reports for 1871. It will not much interest your readers to ascertain which of us first conceived the idea; but seeing that Mr. Smith states that in more than a hundred operations he has divided the mucous membrane as it passes to the nose, I willingly yield him priority in practice. I believe that valuable matter is occasionally buried in Hospital Reports, but I had not studied Mr. Smith's paper in its original shape when I penned my communication. The abstracts and statements of his views which I did consult made no mention of this procedure. I am not astonished at this now that I have consulted the original. May I venture to point out to Mr. Smith that what he calls an "exact description" of the modifications I propose is, as such, simply unintelligible; that a supplementary suture is not identical with a button suture; and that my "gloomy view" of the prognosis in staphyloraphy is fully borne out by the statistics of his operations, for out of twenty-five cases only nine were completely successful at the first attempt.

I am, Sir, &c.,
Ainslie-place, Edinburgh, Oct. 14th, 1879. JOHN DUNCAN.

BIRKENHEAD.

(From our own Correspondent.)

THIS town, which has lately acquired some undesired notoriety through the Tranmere baby-farming case, has now unfortunately been made the site of the operations of an extraordinary female charlatan, who has already made a more or less prolonged stay at Warrington, St. Helens, and other Lancashire towns. She has put up at one of the largest hotels in the locality; she keeps many horses and servants, and travels in a vehicle decorated like a circus car, and is always accompanied by a brass band. Her method of procedure is to drive out to a large plot of unoccupied land adjoining the General Post Office, where her carriage is brought to a stand, and she presents herself to the admiring gaze of the multitude in an oriental costume, brilliant with colour and spangles. After a musical overture by way of introduction and to attract a crowd, the woman's male colleague announces that operations will now be performed gratuitously, and she steps forward and draws teeth for as many candidates as present themselves. This she does with such dexterity as to impress the simple with a sense of her powers, and occasionally she is asked to remove a wen or open an abscess, which of course she is equal to, with the assistance of the band to drown the

shrieks of the victim. When her spectators have been brought to the required pitch of enthusiasm, it is intimated that "Madam has a medicine compounded of 250 herbs, not one of which is grown in Europe, which she will now sell at 2s. a bottle," and forthwith there is a brisk sale, hundreds of bottles being got rid of in an inconceivably short space of time. As soon as there is the least indication that the demand is beginning to flag, the medicine-vendor turns dentist till the old customers have yielded their places to new ones. At this woman's hotel, where she sees people only by tickets, her fees are proportionately high, yet the approaches are often thronged.

While all the local charities are languishing, and the Borough Hospital is burdened with a debt of several hundred pounds, here is a charlatan easily making say £100 a day—I am making my estimate as low as I am able. And what is the attitude of the local press towards the woman? It devotes columns to puffing her, states that "she is the holder of a diploma of the University of Paris," and presents each of its subscribers with a copy of her portrait.

PARIS.

(From our own Correspondent.)

SOME comparative researches on the action of antiseptics were communicated by MM. Gosselin and Bergeron, at the last meeting of the Academy of Sciences. In a first set of experiments, seven tubes, containing each about a gramme of blood, were exposed to the influence of the air. One of these was left entirely unprotected, whilst decomposition was hindered in the others by the addition of six drops of different antiseptic solutions. Putrefaction was found to be but slightly retarded by a one per cent. solution of carbolic acid. One in fifty of the same agent was about as effective as camphorated brandy. Pure and camphorated alcohol delayed decomposition still longer, and a five per cent. solution of carbolic acid entirely prevented it. In a second series from one gramme and a half to two grammes of serum were placed in each tube. Six drops of the preservative fluids were added, in the first place, and a drop more every morning. The development of bacteria was greatly checked, and although a few did appear, the daily addition of the antiseptic drop prevented their multiplication. In no instance were there found any moving filamentous vibrios. A third set of experiments were made to determine the antiseptic power of the same agents by evaporation. Small quantities of fresh blood were placed in the seven vessels, and their orifices closed by several folds of tissue. In one vessel where dry tarlatan alone was used, active vibrios were found on the fourth day. In a second, covered in by Lister's gauze, putrefaction was retarded until the eighth day, as was also the case when the tarlatan was moistened by a one per cent. solution of carbolic acid. A few bacteria appeared on the seventeenth day in the blood protected by gauze moistened with a 1 to 50 solution of carbolic acid, but nineteen days later they had not multiplied. In the other vessels, where alcohol at 86° (camphorated alcohol) and a five per cent. solution of carbolic acid were used to moisten the coverings, no change whatever had occurred on the thirty-sixth day, the blood remaining sweet and free both from bacteria and vibrios. Another experiment was made to ascertain the value of antiseptics in the form of spray, and it was found that alcohol at 86° retarded putrefaction in blood until the ninth day only, whereas the strong solution of carbolic acid had entirely prevented it up to the date of the communication (thirty days), and there was then every reason to suppose that it would not occur.

PLEURO-PNEUMONIA.—This disease has broken out very extensively in North Staffordshire. A farmer named Clarke, living near Longnor, has had six beasts killed, and another, named Roberts, some five miles distant, has had three killed. On four other farms single cows have been killed and farms declared infected. One of the farmers, named Thompson, was fined £10 this week for removing the remainder of his cattle to an adjoining farm. His excuse was that he had not read the notices served on him. Strong measures are being adopted to stop the infection.

Obituary.

DR. JOHN GIBSON FLEMING.

THE subject of this notice was descended from an old and highly-respected Glasgow family, frequently mentioned in the annals of the city. Born in the year 1809, he was educated at the University of Glasgow, where he graduated in medicine in 1830. After a session spent in studying anatomy and surgery in Paris, and a tour in Italy, he settled in Glasgow, and was appointed one of the district surgeons. In this service he nearly succumbed to an attack of typhus fever. For a number of years he was one of the surgeons of the Royal Infirmary. In his subsequent capacity of manager to that institution he did yeoman service to the charity. In 1870 he addressed to his brother managers a letter (which was also published in a pamphlet form), advocating the abolition of the year of ineligibility after eight years' service, which had permanently lost to the infirmary the services of some of its best medical officers. The letter also made a powerful appeal for "free trade" in clinical teaching, in opposition to the method of lecturing by rotation, which was then the rule. This appeal was irresistible, and both changes were effected. When the University moved to new quarters in 1874, it was on Dr. Fleming's suggestion that the managers took chartered powers to affiliate to the institution a medical school; and up to his death he superintended, with unwearied devotion, this department of the institution. To the Royal Infirmary the death of Dr. Fleming is therefore a loss which is altogether irreparable. In the business of the Faculty of Physicians and Surgeons, to whose fellowship he was admitted in 1833, he took a prominent part. He was elected President in 1865, and the honour was repeatedly renewed. For a period of fifteen years he represented the Faculty in the General Medical Council, where, though he did not speak very often, his remarks were always well weighed, and were listened to with respect.

Dr. Fleming was in large practice in Glasgow, a considerable part of it being latterly consultative. He was chief medical adviser of the Scottish Amicable Life Assurance Society, the head office of which was in Glasgow. In 1862 he published a very able and accurate analysis of the experience of that society for a period of thirty-five years, in a small work entitled "Medical Statistics of Life Assurance."

Dr. Fleming was remarkable for the most generous sympathies and a singularly tender heart. With the struggles of young practitioners no one could be more sympathetic, and many was the occasion on which he threw work in their way. Of everything which affected the honour of Glasgow he was keenly sensitive. He had the moral courage to do what he thought was right without regard to whether it offended friend or foe. The death of such a man leaves a large gap in the profession in Glasgow, as it does in not a few aching hearts.

A few days ago Dr. Fleming was seized with the premonitory symptoms of an illness which developed into typhoid fever. The rarity of such an attack in a man of seventy made the profession somewhat sceptical in regard to the first reports. But the diagnosis was never doubtful from the time it was made, and the illness rapidly assumed a hopeless character, terminating fatally on 2nd October. He leaves three sons, one of whom, Mr. William Jas. Fleming, is Lecturer on Physiology in the Royal Infirmary School of Medicine.

PATRICK BLACK, M.D. OXON., F.R.C.P.

IT is a matter of deep regret to record the death of this accomplished physician, which took place on Saturday last, the 11th instant, in Queen Anne-street, Cavendish-square, caused by a somewhat lingering though agonising malady that was diagnosed by his medical friends and attendants, Sir George Burrows, Bart., and Dr. Southey, as cancer of the pancreas. The first symptoms of this malady occurred only twelve months ago—i.e., soon after he had tendered his resignation of the physicianship of St. Bartholomew's Hospital, with which institution, as most of our readers know

well, he had been connected for a great many years. In the early stages of his professional career he was for some time demonstrator of morbid anatomy, and was always remarkably careful and accurate in the diagnosis of disease, so that his compeers attached much value to his opinion in cases of doubt and difficulty. A junior colleague at St. Bartholomew's, to whom we are indebted for most of these notes, remarks that he was justly sceptical as to the efficacy of most drugs the action of which was not immediate or apparent upon ordinary occasions. In the treatment of disease he believed and taught always that nature should be followed rather than forced. As chloroformist at his own hospital for a very long interval, his reign was marked as one unusually free from accidents or complications of any description, and we are not aware that Dr. Black ever had a fatal case. His public appointments included successively all the medical grades at St. Bartholomew's Hospital—i.e., all the ordinary junior appointments, as well as that of physician and also of lecturer on the Principles and Practice of Medicine. He was for some years physician to the Seamen's Hospital when it occupied floating quarters in the *Dreadnought*, when scurvy was a common disease in the British mercantile marine, a member of the Examining Board to the Royal Sea-bathing Infirmary at Margate, and a very prominent and active director of the Clerical, Medical, and General Life Assurance Society, where his great professional experience was of much value to the institution.

His written works include several courses of lectures delivered before the College of Physicians, as well as clever papers severally on "Respiration," "The Use of the Spleen," and "Scurvy in High Latitudes."

ROYAL COLLEGE OF SURGEONS.

AT a Quarterly Council of the Royal College of Surgeons held on Thursday last, Mr. Hancock brought forward the following important motion:—"That, in view of the little prospect which now exists of any immediate medical legislation, a committee be appointed to consider the following questions, and to report thereon to the Council, viz.:—1. The necessary arrangements to be made for the institution of Examinations in Chemistry, Materia Medica, Pharmacy, and Midwifery to be passed by all candidates (not otherwise qualified in these subjects) for the Membership and Fellowship of the College. 2. To advise the Council as to the degrees, diplomas, or certificates which should be accepted as exempting candidates from the necessity of passing the examinations in these subjects. 3. The desirability and the practicability of effecting a voluntary association between the Royal College of Physicians, the Society of Apothecaries, and this College in the establishment of conjoint examinations, comprising all the subjects required for the practice of medicine, surgery, and midwifery. 4. And that, before reporting to the Council, the committee be authorised to enter into such negotiations as they may think proper with the authorities of the Royal College of Physicians and the Society of Apothecaries, for carrying out the proposed association between the three licensing bodies." It was, however, resolved, by a considerable majority, to refer the first two questions only to a committee of the Council to be appointed at the next meeting. It was further resolved that the consideration of the third and fourth propositions be indefinitely adjourned.

Mr. Holmes' motion, "That the question of altering the curriculum with regard to Physiology, in accordance with the alteration recently made in the primary examination, be referred to the Committee on Examination in Anatomy and Physiology," was postponed.

Mr. Simon also proposed, "That, in the rules relating to the formation of the Board of Examiners in Anatomy and Physiology, the rule which restricts the appointment to persons who are Fellows of the College be rescinded." When we explain that the real intention of this proposal was not, as might at first sight be imagined, to make all members of the College eligible for appointment to the Examinerships in Anatomy and Physiology, but rather to throw open these examinerships to persons who have either never felt any inclination, or cared to take the trouble, to become members of the Corporation, it will create no surprise that the motion was negatived by an overwhelming majority.

Mr. John Wood, F.R.S., was elected a member of the Court of Examiners, in place of Mr. Erichsen, resigned; and Dr. Dickinson was elected Dr. Sieveking's successor as Examiner in Medicine.

Medical News.

APOTHECARIES' HALL.—The following gentlemen passed their examination in the Science and Practice of Medicine, and received certificates to practise, on Oct. 9th:—

Hearnden, William Frank, Sutton, Surrey.
Jackson, Mark, Great Torrington, Devon.
Lavies, Joseph W. Y. H., St. George's-road.
Moore, Thomas George James, Reading.
Oglesby, Joseph William, Micklegate, York.

The following gentleman on the same day passed the Primary Professional Examination:—

Hurtley, William Maw, Leeds Hospital.

COLLEGE OF PHYSICIANS IN IRELAND.—At the October examinations the following gentlemen obtained the licence in Medicine and Midwifery of the College:—

MEDICINE.—Deane Bennett, John Noble Bredin, Charles Davidson, John Farrell Easmon, Hugh Parry Jones, George Robert Lawless, Joseph M'Donnell, Michael De Courcy O'Grady, George Thomas Albert Staff.

MIDWIFERY.—Charles Davidson, John Farrell Easmon, Joao Henrique Fialho, Hugh Parry Jones, Joseph M'Donnell, Thos. Beattie Moffitt, Michael De Courcy O'Grady, George Staff.

THE appointment of Surgeon Chiropodist to Her Majesty has been conferred upon Mr. Durlacher, of Old Burlington-street.

THE will of Dr. Radclyffe Hall, who formerly practiced at Torquay, has just been proved, and the personal estate sworn under £90,000.

AT the quarterly meeting of the Directors of the Naval Medical Compassionate Fund, held on the 14th inst., T. Russel Pickthorn, Esq., Inspector-General, in the chair, the sum of £55 was distributed among the various claimants.

IT is stated that the wife of Li-hung Chang, of Shanghai, having fallen ill, and all the native doctors having pronounced her case hopeless, a foreign practitioner was called in and cured her. As an expression of his satisfaction at this result Li-hung Chang has established a hospital under foreign guidance, which is being largely patronised by the higher class of Chinese.

DR. JAMES ADAMS, of Glasgow, one of the victims of the City of Glasgow Bank, has been presented with the title deeds of his house in Cambridge-street, which has been repurchased by the subscriptions of his friends, as an expression of sympathy with him in his affliction, and of appreciation of his character and valuable services as a professional and public man.

SCHOLARSHIPS.—At St. Thomas's Hospital Medical School, Mr. R. M. Williams has obtained the Entrance Science Scholarship of £60, and Mr. B. Relton that of £40.—At St. Mary's Hospital Medical School, Messrs. G. W. Hill and V. H. Veley, B.A., have gained the open Scholarships in Natural Science.

SANITARY INSTITUTE OF GREAT BRITAIN.—The arrangements for the Sanitary Congress to be held next week at Croydon, under the presidency of Dr. Richardson, are now well forward. Mr. Drummond, chairman of the Local Board of Croydon, will open the Sanitary Exhibition on Tuesday, October 21, at 3 P.M.; the exhibition will be the largest and most influential that has yet been held in connexion with the institute. The President's introductory address will be delivered in the public hall at 8 P.M. on Tuesday, and the sections for reading of papers will be opened on each succeeding day for three days by the addresses of the respective presidents of sections—Dr. Alfred Carpenter, Captain Douglas Galton, F.R.S., and Mr. Symons, F.R.S. The *conversazione* will be held on Wednesday, and Professor Corfield's address on "Sanitary Fallacies" will be delivered on Thursday evening. Mr. Edwin Chadwick will also contribute an important communication upon the North Surrey Schools, Anerley, a visit to which will form one of the excursions of the Congress.

THE ROYAL GENERAL DISPENSARY.—On the 9th instant the foundation stone of a new dispensary house, which is being erected by the committee of the Royal General Dispensary, in Bartholomew-close, was laid by the Earl of Dartmouth, the president of the institution. The building is situated in the centre of a poor neighbourhood, and will no doubt be gladly welcomed by those in whose interests it is established. The ceremony was witnessed by the Lord Mayor and several members of the Corporation of the City; and a great amount of enthusiasm was manifested by the poorer classes, who congregated in large numbers round the building.

SOCIETY FOR RELIEF OF WIDOWS AND ORPHANS OF MEDICAL MEN.—A Quarterly Court of the Directors of the above society was held on October 8th, at 5 P.M., in the rooms of the Royal Medical and Chirurgical Society. The chair was taken by the President, Sir George Burrows, Bart., and the meeting was well attended, the change of hour from eight to five o'clock evidently suiting the convenience of the directors. Applications for grants were received from fifty-eight widows, twelve orphans, and three orphans on the Copeland Fund. A sum of £1250 was recommended to be granted at the next meeting. The expenses of the quarter were £36. The treasurer stating that the funds would allow of a donation at Christmas to each widow and orphan now receiving assistance, it was resolved that the same amount be presented this Christmas as upon the last occasion. The deaths of two widows were announced, and two orphans had become ineligible. One member was elected and the death of one reported. The consideration of the question of extending the area of the benefits of the society was adjourned to next meeting.

Medical Appointments.

ATTHILL, W. E. B., L.R.C.P.I., M.R.C.S.E., has been reappointed Medical Officer of Health for the Faversham Port Sanitary District, at £15 per annum, for a year and a half.

BUCK, W. E., M.A., M.D., M.R.C.P.I., has been appointed Physician to the Leicester Infirmary and Fever House, vice Crane, resigned.

CARTER, Mr. D'Arcy, has been appointed an Assistant House-Surgeon to the Leeds General Infirmary, vice Fawcett, whose appointment has expired.

CLARENDON, S., M.B., F.R.C.S.I., has been appointed Certifying Factory Surgeon for the District of Bryansford, co. Down.

FAWCETT, E., M.B., C.M., has been appointed Medical Officer and Public Vaccinator for the Teignmouth District of the Newton Abbot Union, vice Canny, resigned.

GIBBONS, R. A., M.D., has been appointed Assistant-Physician to St. John's Hospital, Leicester-square.

HARVEY, T. P., L.R.C.P.I., M.R.C.S.E., L.S.A.L., has been appointed a Medical Officer to the Hastings and St. Leonard's Provident Dispensary, vice Duke, resigned.

HUTCHISON, G. W., M.D., M.R.C.P.Ed., has been appointed Certifying Factory Surgeon for the District of Chipping-Norton.

JELLY, F. A., has been appointed Clinical Assistant to the Royal National Hospital for Consumption, Ventnor, I.W.

LESTOURGEON, C., M.B., F.R.C.S.E., has been appointed Consulting Surgeon to Addenbrooke's Hospital, Cambridge, on resigning as Surgeon.

LILLIES, H., M.R.C.S.E., has been appointed House-Surgeon and Dispenser to the Tiverton Infirmary and Dispensary, vice Prichard, resigned.

MACDONALD, P. W., M.B., C.M., has been appointed Second Assistant Medical Officer to the Parkside Asylum, near Macclesfield, Cheshire.

MACKEY, G. I., M.B., L.R.C.S.I., has been appointed Medical Officer to the Protestant Orphan School, Waterford, vice Elliott, deceased.

MCLEISH, N., M.B., C.M., has been appointed Medical Officer for the Little Bolton No. 2 District of the Bolton Union, Lancashire.

MACRAE, G. A., M.B., C.M., has been appointed Medical Officer and Public Vaccinator for the Parish of North Uist, Inverness-shire, and Medical Officer to the Lochmaddy Prison and Monarch Island Lighthouse, vice Farquharson, resigned.

MANSON, A. J., M.D., M.R.C.S.E., has been appointed Visiting Surgeon to the Banffshire Lunatic Asylum, Banff, vice Clayton, deceased.

ORAM, A. M., M.B., C.M., has been appointed a House-Surgeon to the Edinburgh Royal Maternity and Simpson Memorial Hospital, for the quarter commencing November 1st.

PORRITT, N., M.R.C.S.E., has been appointed an Assistant House-Surgeon to the Leeds General Infirmary, vice Cheetham whose appointment has expired.

REID, W. S., M.B., C.M., has been appointed a House-Surgeon to the Edinburgh Royal Maternity and Simpson Memorial Hospital for the quarter commencing November 1st.

ROBINSON, T., L.R.C.P.I., M.R.C.S.E., has been appointed Assistant-Surgeon to St. John's Hospital, Leicester-square.

VACHELL, E. S., M.R.C.S.E., has been appointed House-Surgeon to the Radcliffe Infirmary, Oxford, vice Morgan, resigned.

VLIELAND, C. J., M.R.C.S.E., L.S.A.L., has been appointed House-Surgeon to the Kent and Canterbury Hospital, vice Lyddon, resigned.

Births, Marriages, and Deaths.

BIRTHS.

BREWER.—On the 12th inst., at 201, Queen's-road, Dalston, the wife of A. H. Brewer, Surgeon, of a son.

FALKNER.—On the 11th inst., at Kingstown, co. Dublin, the wife of Robert Falkner, L.K.Q.C.P.I., of a daughter.

GODSON.—On the 13th inst., at Upper Brook-street, the wife of Clement Godson, M.D., of a son.

GREENE.—On the 16th inst., at Berry Wood, Northampton, the wife of Richard Greene, of a daughter.

MCGOWN.—On the 9th inst., at Bute-terrace, Millport, Isle of Cumbrae, the wife of John McGown, M.D., of a daughter.

MACKINTOSH.—On the 6th inst., at Clapham-road, the wife of Henry Mackintosh, L.R.C.S.Ed., of a daughter.

NAPPER.—On the 9th inst., at Broad-oak, Cranleigh, the wife of Albert Arthur Napper, M.R.C.S.E., of a son.

WOOD.—On the 14th inst., at Bethlem Royal Hospital, the wife of William Edward Ramsden Wood, M.B., of a son.

MARRIAGES.

COCKELL—HEWITT.—On the 9th inst., at St. Mary's, Stoke Newington, by the Rev. D. O. Harrington, B.A., Vicar of St. Philip's, Dalston, Frederick Edgar Cockell, jun., M.R.C.S.E., of Dalston, to Katie, youngest daughter of the late William Hewitt, of Stoke Newington.

GROSS—YATES.—On the 14th inst., at St. John's, Higher Broughton, Manchester, by the Rev. F. B. Wright, M.A., Rector, Charles Gross, L.R.C.P.L. &c., Medical Superintendent at St. Saviour's Infirmary, Walworth, London, S.E., eldest son of Charles Gross, of Ramsgate (late of Erith), to Constance, youngest daughter of the late William Yates, of Manchester, and Hadley Hall, Salop.

DEATHS.

BLACK.—On the 12th inst., at Queen Anne-street, Patrick Black, M.D., aged 66.

CAMPBELL.—On the 12th ult., at Stoney Hill, Jamaica, Alexander Bowerbank Campbell, L.R.C.P.Ed., M.D.

DOWSON.—On the 8th inst., at West Humble, near Dorking, Edward Dowson, M.D., aged 47.

FLEMING.—On the 11th inst., at Hope Bank, Dunoon, Joseph Fleming, F.F.P.S.G., late of Glasgow, aged 78.

INNES.—On the 5th inst., at Rhyl, James Innes, M.R.C.S.E., formerly of the Hon. East India Company's Madras Medical Service.

SHEDLOCK.—On the 9th inst., at Madeira, Rose Anna, fourth daughter of the late Rev. John Shedlock, M.A., aged 29. Friends will kindly accept this intimation.

N.B.—*A fee of 5s. is charged for the insertion of Notices of Births, Marriages, and Deaths.*

Notes, Short Comments, and Answers to Correspondents.

IMPOSSIBLE SPECIALTIES.

WE do not question the need of certain specialties in practice—for example, practical ophthalmology must be a specialty,—because particular qualifications are necessary on the part of an operator; but there are certain specialties which are, in a scientific sense and on the plainest grounds, impossible. Perhaps the most prominent of these is the treatment of disease of the organs of procreation. There are insuperable obstacles to the separation of this class of maladies from general practice, and there is not a particle of reason why such a specialty should be desired. Anything more deplorable than the fate of a person under the treatment of a specialist for some malady of the nature to which we have alluded it would be difficult to imagine. He is not only involved in social difficulties of the most formidable description, but he is cut off from the advantages of general treatment, by which alone, possibly, the local disease can be thoroughly cured. There is a grievous peril in the isolation of this class of affections from general practice, which it is surprising the public should not at once recognise. If there be one variety of morbid phenomena which ought, more than others, to be treated by a medical man acquainted with the constitution of the sufferer, and able to keep him under continuous observation, it is this. Instead of placing himself under the care of a specialist for the treatment of disease of the class to which we allude, a patient should be more than commonly careful to secure the advantage of advice from the practitioner who best knows how he is likely to be affected, and how it may be expedient to attempt a cure. We are induced to make these special observations by the frequent occurrence of cases in which the most disastrous consequences ensue from omission to take the simple precaution to which we have alluded—namely, that of repairing at once to the family, or previous personal, adviser. The matter is so serious that we feel bound to make it the subject of pointed remark.

Medicus.—The question was fully answered in a leading article in our last week's issue.

SLAUGHTER-HOUSE IMPROVEMENTS.

THE inhabitants of Cardiff are to be congratulated on the acquisition of a new model slaughter-house, sufficiently large to meet all the requirements of a population of 120,000. The system is similar to that adopted in so many French towns and also at Manchester. There are stalls for keeping the cattle and pigs before they are slaughtered, other stalls for the horses waiting to carry the meat to town, and there is a dead-meat market. The old private slaughter-houses will now be all closed, to the great benefit of public health, while the public purse will profit by the sale of the sites they occupied for general building purposes. Nor will the butchers be losers; for in model slaughter-houses there is far less waste; the blood and every part of the animal is saved and utilised. Finally, the inspectors will be able more effectually to prevent the sale of unwholesome food. We trust that all other large towns will soon see their way to follow this example.

S. G. F.—The suggestion to abandon the use of coffins is not new.

INGUINO-OVARIAN HERNIA.

To the Editor of THE LANCET.

SIR,—Will you permit me to offer a few remarks on the abstract of this case which appears in THE LANCET of to-day (October 11th)? I would not have troubled you had I been able to attend the meeting; but I was prevented from doing so, as I am suffering from the effects of a severe accident which happened to me in Ireland nine weeks ago.

It is stated that "they were removed under carbolic spray, but the dressing of the wounds appears to have been imperfectly antiseptic; the wounds suppurated, but the patient completely recovered." The wounds were dressed by myself, and every antiseptic precaution was carefully observed. Indeed I feel sure the suppuration was not the result either of "imperfect antiseptic dressing" or of want of care, but was rather owing to the mode of securing the pedicles by transfixing them in the upper third of the wounds—the plan adopted by previous operators.

In commenting on this part of my paper, it is therein remarked that "these facts pretty clearly show that the present mode of dealing with the pedicle in these cases is unsatisfactory and open to many objections as a means of septic poisoning. Should I again be called upon to operate in a similar case, I should certainly try the clamp and actual cautery, removing as much of the pedicle as possible, in order that the wound might be more completely closed. My own observations, supported by the experience of others, would lead me to believe that this class of pedicle is pre-eminently adapted for the actual cautery treatment."

Dr. John Williams and Dr. Galabin, in their remarks, expressed the opinion "that all cases of supposed congenital hernia of the ovaries were really cases of undescended testicles." In reply to these observations, I would adduce Esmarch's case—of which mine appears to be a *fac-simile*,—mentioned in my paper, where it is distinctly stated that "the ovaries manifested ovular development."

Dr. Routh "thought that the absence of the uterus could only be decided with certainty by the introduction of the hand into the rectum." This objection was anticipated in the following passage: "I am quite aware that it may be objected by some of the Fellows present that the absence of the uterus cannot be certainly diagnosed without the introduction of the hand into the rectum. For my own part, however, I think such excessive zeal as undesirable as it is, in my opinion, unnecessary." To this I have nothing to add.

I am, Sir, your faithful servant,

Chester-square, S.W., Oct. 11th, 1879. THOMAS CHAMBERS.

H. C.—Any kind of hernia under the Regulations is sufficient to disqualify; but perhaps, with the present paucity of candidates, the condition of things mentioned might be passed over. Our correspondent should write to the authorities. The new Warrant is not yet issued.

"ONE CAUSE OF BATHING ACCIDENTS."

To the Editor of THE LANCET.

SIR,—Referring to some remarks which appeared in THE LANCET recently with regard to the immersion of the whole body immediately in bathing, allow me to furnish you with my own unprofessional experience.

I always plunged headlong into the water; I had done so twenty times this year without suffering any inconvenience. On the last occasion, however—one morning before breakfast,—I felt a sudden chill after the plunge. I proceeded to perform a distance I had done previously with ease, and when in deep water suddenly experienced the awful sensation of complete exhaustion, and almost instantly sank slowly in an upright position; then followed an attempt to propel myself, but with trifling success. My arms first succumbed; I gradually lost consciousness, but not before I had felt that help was near in the person of a friend.

Yours &c.,

October, 1879. P.

PROVIDENT DISPENSARIES.

To the Editor of THE LANCET.

SIR,—Will any of your readers kindly favour me at the undermentioned address with rules and other particulars for establishing a provident dispensary in an agricultural district?

I remain, Sir, yours &c.,

Hartley-row, Hants, October, 1879. H. MATURIN.

THE ERASMUS WILSON FUND

WE would remind those of our readers who are members of the College that the 31st instant is the last day on which applications can be received by the Secretary of the College with a view to giving lectures under the Erasmus Wilson Fund during the year 1880. The special object of the Fund is, as we have before announced, to promote the making of original researches in pathology by members of the College, and the publication of the results by lectures to be delivered at the College.

A CORRESPONDENT, who signs himself *Index*, might indicate his name, address, and object, which last is not to us very apparent at present.

Mr. W. K. Rix is thanked.

Bullock.—See a special note on the subject in another column.

TREATMENT OF CHOLERA BY THE HYPODERMIC INJECTION OF MORPHIA.

To the Editor of THE LANCET.

SIR,—As I intimated in my last, I have no personal experience of choleraic treatment in the East, and quite agree with your correspondent that my treatment may not be at all applicable to meet the scourge in that climate. I need not say I hope it may be long before it again visits these islands. But I have felt it right to call attention once more to what was here indisputably curative; and, assuming this latter assertion to be true, most important questions arise from that fact: What is the cause of the sudden shock which suddenly prostrates the sufferer as though by a material mortal blow, and death following so quickly? Is the serous rheum active or passive? Is the vomiting merely caused by the volume of serum poured into the stomach? Why do not the pulmonic cells become filled from their membranes?

Now, as many of our most distinguished men earnestly advocated the elimination of what they held to be the cause of disease—i. e., some subtle virus, to be purged away by castor oil &c.,—and as this course most signally failed, whilst the direct contrary was successful, it follows that the *materies morbi* influenced the spiritual rather than the material (so to say) department of the animal economy, or the nervous system presiding over organic life. Evidently this question is of vital importance in the treatment of the disease wherever it manifests itself. All who have seen it must be struck with the singular fact that, when recovery has taken place, the patient is left without any traces of blood-poisoning, and has simply to recuperate from the exhausting effects of the drain of vital fluid, the mental faculties having throughout been unimpaired. If care be taken as to the functions of the liver and other secretory organs, the cure will be rapid and permanent.

As to the similarity of the English to the Eastern disease. At Hemel Hempstead the suddenness of attack was remarkable, and under ordinary treatment death often followed in four or five hours. I remember, in a woman, a striking example of the suddenness. While sitting with her children at the fireside, apparently in perfect health, she fell from her chair vomiting and purging; and a strong young man, a few doors distant, was attacked at the same time. The locality was near the river-side, one mile from Hempstead, and they were the only cases in that district, so far as I know. Both recovered. In both there was a total suppression of urine in the first stage, and free secretion in the second. The man required the aid of the catheter, after a few hours, for relief of an enormously distended bladder; this was only required once. The recovery in both cases was unusually rapid.

Hoping that there are young and vigorous minds who may deem the questions which I now offer, and which are deduced from facts, not unworthy of serious investigation,

I am, Sir, yours respectfully,

Trafalgar-square, Chelsea, Oct. 14th, 1879. ARTHUR SARJEANT.

THE LATE DR. HENRY MOON, OF BRIGHTON.

To the Editor of THE LANCET.

SIR,—On Monday, October 6th, I was one of the mourners who followed Dr. Moon to his last resting-place in the family vault in Brighton Cemetery. Dr. Moon was a genuine Sussex man; he was born at Horsham, went to school at Steyning, practised as a general practitioner at Lewes, afterwards as a physician at Brighton, and died at St. Leonard's-on-Sea. His medical school was Guy's, where he was a pupil of Bright and Sir Astley Cooper, and where he was beloved by all who knew him. He commenced practice in Lewes, where he soon had a large *clientèle*, and where for four years and a half I was his pupil. He was most highly and deservedly esteemed in Lewes, in Brighton, and in the county of Sussex, and I myself owe much to his example and precept, for he lived and died a perfect Christian gentleman.

Yours truly,

DANIEL HOOPER, B.A. & M.B. Lond.,
Senior Physician to the Surrey Dispensary.

Trinity-square, S.E., Oct. 13th, 1879.

PORT WINE!

To the Editor of THE LANCET.

SIR,—Is nitrite of amyl a usual adulterant of (so called) port wine? To-day, in a poor man's house, I distinctly differentiated the smell of nitrite of amyl from the vinous and other ethers mixed in a freshly-drawn bottle of port. If this be so, the proverbial headache resulting from "fine old military" is explained.

Yours &c.,

Melksham, Wilts, Oct. 10th, 1879. S. GROSE, M.D.

BAD SEWERAGE.

WE recently mentioned that the wet weather had prevented the completion of the Harwich sewer by the time specified in the contract. It appears now, however, that the authorities have had to contend not merely against bad weather, but bad workmanship has proved even more mischievous. The storage sewer, which was to hold a week's sewage, has just been examined by Major Brine, R.E., on behalf of the War Department, and the concrete has been found so defective that, in spite of the great outlay, the entire work is condemned, and must be built over again.

"FRACTURE OF THE UPPER AND LOWER JAWS: A NEW MODE OF TREATMENT."

To the Editor of THE LANCET.

SIR,—Reading the account of Mr. Walter Norman's case in last Saturday's LANCET has led me to send you a few particulars of a similar plan of treatment adopted in a case which came under my care four years ago. Considering, however, at the time that the idea of so treating an ordinary fracture of the jaw could have nothing original about it, I neglected recording the facts.

Mr. D——, a short, heavy man, was thrown out of his dog-cart, about six miles from here, at the latter end of September, 1875, and was, I believe, removed to a neighbouring infirmary. There he was visited, and afterwards brought home by his own physician, Dr. Thorburn, of Manchester. At Dr. Thorburn's request I undertook the surgical part of the case, which included an immense scalp wound at the back of the head; the *left* ear torn through in two places, so that when first seen it must have hung down like a torn rag; and a fracture of the lower jaw on the *right* side, between the bicuspid and canine teeth. At first the fracture was treated in the usual manner by the four-tailed bandage and gutta percha. This plan, however, was soon found to be of no use, as not only the restlessness of the patient, who was suffering at times from slight delirium, but the necessity of removing all bandages for the daily dressing of the other injuries entirely disturbed any support to the jaw. By this time suppuration was going on freely in the mouth, and the stench arising therefrom made it neither beneficial to the patient nor agreeable to the attendants. Under these circumstances it was agreed upon by Dr. Thorburn and myself that a cast of the jaw should be taken, and a splint, so to speak, made whereby the broken ends of the bone might be kept in apposition. To this end the services of Mr. Farnsworth, dentist, Oxford-street, were called in, and he making a careful impression of the mouth, a vulcanite plate was so constructed and accurately fitted as to do away with the necessity of all other appliances and supports. Unfortunately, however, the plate proved too weak, and, as it shared the same fate as the jaw itself before the morning, it had to be replaced the following day by one much stronger. This acted in every way satisfactorily and successfully; and as it did not cause the slightest pain or inconvenience, and taking also into consideration the fact that suppuration had taken place before it was applied, I took the precaution of allowing it to remain on fully seven weeks. There is, I am pleased to add, perfect union, and my patient is at the present time enjoying as great a freedom and usefulness of his jaw as he ever did.

I am, Sir, yours faithfully,

Manchester, Oct. 9th, 1879. HENRY CARTMEL, M.R.C.S.E.

URBAN SEPULTURE.

To the Editor of THE LANCET.

SIR,—My attention having been drawn to your recent warnings on the condition of metropolitan cemeteries, I venture to bring under your notice the enclosed pamphlets—viz., "Practical Suggestions for the Establishment of National Cemeteries (1849)"; and "On the Past and Present State of Intra-mural Burying-places, with Practical Suggestions for the Establishment of National Extra-mural Cemeteries (1851)."

Having in every way laboured to convince my countrymen of the physical and moral mischiefs inseparably connected with, and resulting from, the practice of inhuming the dead in the midst of the living—having in my writings and before two Select Committees of the House of Commons, by irrefragable testimonies, demonstrated the wrong,—I venture to affirm that thirty years ago I pointed out the remedy.

In February, 1842, in response to my petition to the House of Commons, a Select Committee (Health of Towns—Effect of Interment of Bodies), of which W. A. Mackinnon, Esq., was appointed Chairman, commenced the examination of witnesses on the 17th March, and concluded their labours on the 5th May. The Report states that "After a long and patient investigation your Committee cannot arrive at any other conclusion than that the nuisance of interments in large towns, and the injury arising to the health of the community from the practice, are fully proved."

Early in the year 1842, such was the result of "a long and patient investigation" by a Committee appointed to inquire and report on the burial in towns question. Then it was not deemed advisable to deal with the condition of the soil, the location, or the "management" of the so-called suburban cemeteries, although even at that period the inquiry would have yielded valuable results.

How much longer the pestilent intra-mural burial system, with its "management," may be permitted to continue seems uncertain. Surely it cannot be necessary to adduce further additional proofs of blood-poisoning from graveyard and vault atmospheres—in a word, from the poisoning of earth, air, and water.—Yours faithfully,

October 4th, 1879. GEORGE ALFRED WALKER.

H. J.—No more than one person affected with mental disability can be received into a house without a licence being obtained *for the premises*. This is in addition to the question of an order and certificates for each individual inmate. It is a perilous practice to receive persons of "weak intellect" into a family without giving notice to the Commissioners in Lunacy, and one we cannot approve. The Commissioners may at any moment, and as a matter of public duty ought to, investigate the cases so received, to determine whether they are not, in fact, cases of insanity. The only prudent course is at once to communicate with the Secretary to the Commissioners, and state what has been done, asking guidance, and acting on the advice given. It would involve a serious risk, and we think would be wrong to do as proposed. It is not possible to frame such a definition of "mental weakness" as will exclude insanity.

Heidelberg does not approve of women dispensers. Nor do we.

PLASTER-OF-PARIS JACKETS.

To the Editor of THE LANCET.

SIR,—Now that the use of Sayre's plaster jacket in spinal disease has proved to be such a success, is it not probable that its use in spinal injury might also be of great value? For instance, in those cases of spinal irritation from railway injury, or from violent falls upon the back, where it would be necessary to keep the spine quiet and fixed, without altogether preventing the patient from taking exercise. But it seems to me that it would be most useful in cases of fracture of the spine, more particularly in the lower dorsal and lumbar regions. In a case of fracture higher up, where the thoracic respiration is impeded, the respiration being mostly abdominal, it would perhaps not be as suitable. The "jacket" might also be the means of preventing the troublesome bedsores which sooner or later always appear over the sacrum. A pad might be applied over the sacrum, similar to the stomach pad, and withdrawn, thus leaving a space between the "jacket" and the sacrum. To prevent this space from becoming the receptable of excreta &c., fresh tow might be inserted and removed each day.

I hope some one who is seeing these cases frequently will give the "jacket" a trial, and publish his experience, as I certainly would should such a case come under my care.

I am, Sir, yours obediently,

ALFRED KEBBELL, M.R.C.S. Eng.

Flaxton, York, Oct. 14th, 1879.

To the Editor of THE LANCET.

SIR,—"Prevention is better than cure." "H. A. C." need not paste his plaster-of-Paris jackets over with paper in order to prevent the plaster from crumbling away. A fortnight ago I had the good fortune to hear Dr. Sayre give a demonstration on his "jacket," and he said the plaster-of-Paris only crumbles away when too much has been applied. The prepared bandages contain sufficient, and it is quite unnecessary to rub in an extra quantity during and after the application of the bandage.

Your obedient servant,

Kennington-park, Oct. 13th, 1879. J. J. R.

To the Editor of THE LANCET.

SIR,—"H. A. C." asks your readers to oblige him with their experience of the poroplastic jacket. If he will write me on what points he desires to obtain information, I shall be very pleased to reply to him. To state my experience would necessitate my sending you a letter of such length as would probably prohibit its appearance in your columns.

Yours obediently,

Grosvenor-street, W., Oct. 15th, 1879. F. R. FISHER.

A Competitor.—The value of the Jacksonian Prize was formerly £10; but now, thanks to a late member of the Council, Mr. Chas. Hawkins, the Inspector of Anatomy, it is worth about £12, and will gradually increase in value.

Anglo-Indian should apply to the Office of the Crown Agents for the Colonies, Downing-street.

Dr. W. P. Peck.—The next meeting of the British Medical Association will be held at Cambridge.

STRANGULATED CONGENITAL INGUINAL HERNIA IN A CHILD FOURTEEN DAYS OLD.

To the Editor of THE LANCET.

SIR,—I enclose you a copy from my note-book of a case of strangulated hernia in a child fourteen days old. I am prompted to do so as there is a case occurring in a child three weeks old reported in your issue of the 4th inst., and which is stated to be probably the youngest case on record.

A male child, aged fourteen days, was admitted to the Liverpool Royal Infirmary, under the care of Mr. Bickersteth, on August 12th, 1873, suffering from a congenital inguinal hernia on the right side, which had been strangulated for three days. As the case had received various treatment before admission, it was decided to operate at once (2 P.M.) The usual operation of herniotomy was performed, and the sac opened. On exposure, the gut was found to be gangrenous, and was therefore left in situ. Soon after the operation the gut gave way. The case terminated fatally the same evening.

Yours faithfully,

Poole, Oct. 9th, 1879. H. A. LAWTON, L.R.C.P. Lond., &c.

FOREIGN DEGREES.

To the Editor of THE LANCET.

SIR,—When reading "Scrutator's" letter in your issue of last week, it struck me that he, together with many others, is giving himself a great deal of unnecessary trouble about foreign degrees.

I should be the first to decry any system whereby degrees were obtained for the mere purchase money or after a nominal examination, and the possessor of any such degree would soon find his own level either in England or abroad.

The General Medical Council refuse to register the holder of a foreign degree, and very properly so, for they possess no power over the University that grants it; but, having done this, it appears to me that they have done all that is necessary, and all that they reasonably can do. What would "Scrutator" think (supposing he possesses a British degree) if, on going to reside in France, he were seized upon and told not to use his title there? I am afraid he would not cherish a fond remembrance of foreign politeness. The holder of a M.D. degree from the University of France is as much a *doctor* as the holder of one from a British University; and if "Scrutator" looks to the British Parliament to pass an Act for the simple purpose of preventing the former gentlemen from using their title in this country, I am afraid his wishes are far from being realised. I remain, Sir, your obedient servant,

Oct. 13th, 1879. MEDICUS.

To the Editor of THE LANCET.

SIR,—I think that the controversy with regard to foreign degrees may be briefly summed up thus: That any person having such a degree should be allowed to call himself "Dr." or "M.D.," but should not be allowed to register the same or to practise in this country without a British diploma. In fact, it should be looked upon as similar to a foreign title of nobility (as Count), which simply confers on bearer more or less social distinction, but is not legally recognised when held by a British subject, nor in any case does it entitle to the privileges of a Peer of England. Yours &c.,

October 14th, 1879. W. AKERMAN.

COMMUNICATIONS, LETTERS, &c., have been received from—Dr. Dowse; Mr. Fisher, London; Dr. Barclay, London; Mr. Buck, Leicester; Mr. Rennie, Ashton-under-Lyne; Mr. Merlin, Sutton; Dr. Ealer, Belfast; Dr. Maclachlan, Dumbarton; Dr. Thorburn, Sandwich; Mr. Durlacher; Dr. Duncan, Edinburgh; Messrs. Calvert and Co., Manchester; Dr. Woodward, Worcester; Major M'Coy, London; Dr. Watson, Penistone; Dr. Hicks, Hendon; Mr. Blackett, London; Messrs. Holbrook and Son, Portsmouth; Mr. Christie, Huddersfield; Mr. Appleton, Highgate; Mr. Bell, London; Dr. Scatliff, Brighton; Mr. Lawton, Poole; Dr. Hime, Sheffield; Mr. Harrison, Liverpool; Dr. King, Godalming; Mr. Maturin, Winchfield; Mr. Cartmel, Manchester; Dr. Marshall, Nottingham; Dr. Illingworth, Natal; Mr. Chapman, Dublin; Mr. Lees, Oldham; Mr. Ricks, Bradford; Dr. Ega, Cairo; Mr. Bullock, Manchester; Dr. Grose, Melksham; Mr. Scott, Manchester; Messrs. Barroughs and Co., London; Dr. Hooper, London; Dr. Peck, Davenport, U.S.A.; Mr. Morton, Bambridge; Mr. Courtenay, Jamaica; Dr. Curran, Warrington; Mr. Lacey, London; Dr. Woodhouse, Fulham; Dr. Duncan, Glasgow; Mr. T. Chambers, London; Mr. Walker, Sponton; Mr. Ottaway, Salisbury; Mr. Jelly, Ventnor; Miss Greeves, Hammersmith; Mr. M'Finlay, Ballycroy; Mr. Macarthy, St. George's; Dr. Collins, London; Mr. Thomas, Birmingham; Mr. Sarjeant, London; Dr. Paton, Edinburgh; Mr. Lewis, Hay; Messrs. Craker and Co., London; Mr. Akerman, London; Dr. Greatrex, Laughton; Mr. Morton, New Brompton; Mr. Eastwood, Huddersfield; Mr. Dicey, Northampton; Mr. Clark, Macclesfield; Mr. Berridge, Loughborough; Medicus; P. A. H.; S. J. F.; F. M. K.; An Occasional Correspondent, Zululand; Heidelberg; P.; K. J. R.; An English Surgeon, South America; L.R.C.P.; Anglo-Indian; &c.

LETTERS, *each with enclosure*, are also acknowledged from—Dr. Finness, Mauritius; Dr. Meadows, London; Mr. Harding, Ipswich; Mr. Towle, Manchester; Messrs. Robinson and Co., Rotherham; Dr. Maclaren, Blairgowrie; Mr. Maile, Faversham; Mr. Starkey, Reading; Mr. Day, Dorchester; Mr. Colbran, Tunbridge Wells; Messrs. Leader and Sons, Sheffield; Messrs. Swan and Proctor, Newcastle-on-Tyne; Dr. Monro, Newtown; Mr. M'Namara, Uxbridge; Mr. De Bach, Woodbridge; Mr. Newton, Exeter; Messrs. Oliver and Co., Hawkhurst; Mr. Bellamy, Bridlington; Mr. Oliver, Dublin; Mr. Whitlock, Linton; Dr. Reed, Ilfracombe; Dr. Walker, Aldborough; Mr. Welsh, Louth; Dr. Harding, Whittlesea; Mr. Blyth, Brotton; Dr. Thomas, Sheffield; Messrs. M'Gee and Co., Belfast; Mr. Gillon, Keighley; Dr. Penwick, London; Mr. Charteris, Hipperholme; Dr. Hebblethwaite, Bawtry; Mr. Newman, London; Dr. Balfour, Alton; Messrs. Evans and Barnes, West Bromwich; Mr. Hamilton, Headford; Mr. Skrimshire, Abergavenny; Messrs. Jolly and Sons, Norwich; Mr. Greene, Berry Wood; Mr. Price, Swindon; Practitioner; M. L., Newcross; M. V., Cardiff; M. B.; Medicus No. 10; A.; Assistant, Hayes; M. D.; Medicus, Leeds; Veritas, Weymouth; Medicus, Ramsbottom; A. B., Retford; J. B., Leeds; F.R.C.P.; W. R. D.; Griffiths, Ebbw Vale; Hoc; H., Ramsgate; O. H. G.; Medicus; Graduate, Newcastle-on-Tyne; A. B., Crewe; Medicus, Kennington; E. W. S.; L. S. A., Mount Radford; B., Peterborough; Doctor, Rochford Bridge; R. P.; R. D.; P. C. H., Walton-on-the-Naze; Alpha, Kennington; W. H. J.; Lena, Shrewsbury; Hector, Leighton-Buzzard; A., Dudley Port; D. S., Aberdeen; H. D. A., Windsor.

City Press, Indian Herald, Morning Chronicle, Birkenhead News, Bristol Times, Chelsea News, &c., have been received.

METEOROLOGICAL READINGS.

(Taken daily at 8 a.m. by Steward's Instruments.)

THE LANCET OFFICE, Oct. 16th, 1879.

Date.	Barometer reduced to Sea Level, and 32° F.	Direction of Wind.	Dry Bulb	Wet Bulb	Solar Radiation in Vacuo	Max. Temp. in Shade	Min. Temp	Rain fall.	Remarks at 8.30 A.M.
Oct. 10	30·47	N.E.	46	45	..	58	39	..	Foggy
,, 11	30·55	E.	45	45	..	53	44	..	Foggy
,, 12	30·53	E.	47	44	..	55	42	..	Foggy
,, 13	30·43	E.	45	45	..	52	42	..	Foggy
,, 14	30·29	W.	49	48	..	55	44	..	Overcast
,, 15	30·18	N.	43	40	..	49	33	0·02	Fine
,, 16	30·24	N.	40	36	..	50	34	..	Bright

Medical Diary for the ensuing Week.

Monday, Oct. 20.

ROYAL LONDON OPHTHALMIC HOSPITAL, MOORFIELDS.—Operations 10½ A.M. each day, and at the same hour.
ROYAL WESTMINSTER OPHTHALMIC HOSPITAL.—Operations, 1½ P.M. each day, and at the same hour.
ST. MARK'S HOSPITAL.—Operations, 2 P.M.
METROPOLITAN FREE HOSPITAL.—Operations, 2 P.M.
ROYAL ORTHOPÆDIC HOSPITAL.—Operations, 2 P.M.
MEDICAL SOCIETY OF LONDON.—8½ P.M. The President (Dr. John Cockle) will deliver an opening Address.—Dr. B. W. Richardson, "On the Sphygmophone in Diagnosis."

Tuesday, Oct. 21.

ST. MARK'S HOSPITAL.—Operations, 9 A.M.
GUY'S HOSPITAL.—Operations, 1½ P.M., and on Friday at the same hour.
WESTMINSTER HOSPITAL.—Operations, 2 P.M.
NATIONAL ORTHOPÆDIC HOSPITAL.—Operations, 2 P.M.
WEST LONDON HOSPITAL.—Operations, 3 P.M.
PATHOLOGICAL SOCIETY OF LONDON.—8 P.M. The following Specimens will be shown:—Growth in Left Ventricle, with Embolism of the Brachial and other Arteries; Mollities Ossium, with Myeloid Tumour; Caries of Spine affecting Hip-joint and Aorta; Small Round-celled Sarcoma; Papilloma of Fallopian Tubes; Disease of both Supra-renal Capsules without Bronzing; Calvaria of Congenital Syphilis; Lymphadenoma; Rupture of the Aortic Valves; Congenital Hernia with Undescended Testicle; Syphilitic Disease of the Testicle; &c. &c.—The Specimens will be exhibited at 8 P.M.

Wednesday, Oct. 22.

MIDDLESEX HOSPITAL.—Operations, 1 P.M.
ST. BARTHOLOMEW'S HOSPITAL.—Operations, 1½ P.M., and on Saturday at the same hour.
ST. THOMAS'S HOSPITAL.—Operations, 1½ P.M., and on Saturday at the same hour.
KING'S COLLEGE HOSPITAL.—Operations, 2 P.M., and on Saturday at 1 P.M.
LONDON HOSPITAL.—Operations, 2 P.M., and on Thursday and Saturday at the same hour.
GREAT NORTHERN HOSPITAL.—Operations, 2 P.M.
UNIVERSITY COLLEGE HOSPITAL.—Operations, 2 P.M., and on Saturday at the same hour.
SAMARITAN FREE HOSPITAL FOR WOMEN AND CHILDREN.—Operations, 2½ P.M.

Thursday, Oct. 23.

ST. GEORGE'S HOSPITAL.—Operations, 1 P.M.
ST. BARTHOLOMEW'S HOSPITAL.—1½ P.M. Surgical Consultations.
CHARING-CROSS HOSPITAL.—Operations, 2 P.M.
CENTRAL LONDON OPHTHALMIC HOSPITAL.—Operations, 2 P.M., and on Friday at the same hour.

Friday, Oct. 24.

ST. GEORGE'S HOSPITAL.—Ophthalmic Operations, 1½ P.M.
ST. THOMAS'S HOSPITAL.—Ophthalmic Operations, 2 P.M.
ROYAL SOUTH LONDON OPHTHALMIC HOSPITAL.—Operations, 2 P.M.
QUEKETT MICROSCOPICAL CLUB.—8 P.M. Mr. A. Martinelli, "On the Germination of a Seed."
CLINICAL SOCIETY OF LONDON.—8½ P.M. Dr. Southey, "On two Cases of Acute Rheumatism."—Mr. Lawson, "On Cancer of the Breast following upon Eczema of the Nipple of long standing."—Dr. Wilks (of Ashford), "On a Case in which a Man was Struck by Lightning."

Saturday, Oct. 25.

ROYAL FREE HOSPITAL.—Operations, 2 P.M.

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